

92 37001

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henrietta Marie Turecek						2. DATE OF DEATH MONTH DAY YEAR 12 28 92		3. TIME OF DEATH 3:00 P.M.	
4. SOCIAL SECURITY NUMBER 215-07-2243		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02 06 14		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Center						9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Clarksville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11746 Rt. 108				10f. ZIP CODE 21029		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11 Elementary/Secondary (8-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk			16b. KIND OF BUSINESS/INDUSTRY State of Md. Police Dept.		
17. FATHER'S NAME (First, Middle, Last) Joseph Turecek						18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA PROCHAZKA			
19a. INFORMANT'S NAME (Type/Print) Carolyn Langston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11746 Rt. 108 Clarksville, Md. 21029					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens			20c. LOCATION — City or Town, State Timonium, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Christina D. Kopy...				22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Baltimore, Maryland 21086					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):									
b. Urinary Tract Infection DUE TO (OR AS A CONSEQUENCE OF):									
c. Dementia DUE TO (OR AS A CONSEQUENCE OF):									
d. Organic Brain Syndrome									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER John D. Milto MD				29c. LICENSE NUMBER D34124		29d. DATE SIGNED (Month, Day, Year) 12/29/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN D. MILTO, M.D. 7600 OSLER Dr #213 Towson, Md 21204									
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE John Davidson-Rodell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37002

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILTON P. TANKERSLEY, JR.				2. DATE OF DEATH MONTH 12 DAY 25 YEAR 92		3. TIME OF DEATH 9:58A M			
4. SOCIAL SECURITY NUMBER 218-03-7709		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-21-17		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) St. Joseph's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Towson			9c. COUNTY OF DEATH Baltimore		
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 8133 Pleasant Plains Road				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Buyer		15b. KIND OF BUSINESS/INDUSTRY Martin Marietta					
17. FATHER'S NAME (First, Middle, Last) Thomas Paul Tankersley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Estelle Hubbard					
19a. INFORMANT'S NAME (Type/Print) Milton P. Tankersley Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Southware Rd Bel Air, Md. 21014					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		DATE 12/28		20c. LOCATION — City or Town, State Baltimore Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Christina L. Kopycz				22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Baltimore, Md 21286					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction IMMEDIATE CAUSE (Final disease or condition resulting in death) → Approximate Interval Between Onset and Death: 5 days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS PNEUMONIA									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER A.H. Ghiladi							
29c. LICENSE NUMBER D-12849		29d. DATE SIGNED (Month, Day, Year) 12-25-92							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) A.H. GHILADI, M.D. 7600 OSLER Dr. TOWSON, MD 21204									
31. DATE FILED (Month, Day, Year) DEC 31 1992		32. REGISTRAR'S SIGNATURE Julia Davidson							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5005 70



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92 37003

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Eula Wilds				2. DATE OF DEATH MONTH DAY YEAR 12/29/92				3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 213-76-0550		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-25-1899		8. BIRTHPLACE (State or Foreign Country) South Carolina					
9a. FACILITY NAME (If not institution, give street and number) 803 N. WOLFE ST.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH					
10a. STATE MD.				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 803 N. WOLFE ST.				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? U. S. A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EVANGELIST		16b. KIND OF BUSINESS/INDUSTRY C. O. G. I. C.									
17. FATHER'S NAME (First, Middle, Last) PHAROAH ROGERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) BETTY ROGERS									
19a. INFORMANT'S NAME (Type/Print) MARIE TA SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 N. WOLFE ST. Balto. Md. 21205									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE NATIONAL 1/4/93		20c. LOCATION — City or Town, State BALTIMORE									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Derrick C. Jones				22. NAME AND ADDRESS OF FACILITY DERRICK C. JONES F.H. 4611 PARK HEIGHTS AVE. 21215									
23. PART I. Enter the disease(s), or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Infection - Probable Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, stroke , Decubitus Ulcers, Peripheral Vascular Disease								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Keith A. von Eigen MD								29c. LICENSE NUMBER D42385		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Keith A. von Eigen													
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE John Davidson-Hendell									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital and signed physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37004

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PRISCILLA D. WILLIAMS				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92		3. TIME OF DEATH 6:47 P.M.	
4. SOCIAL SECURITY NUMBER 239-38-0791		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	7. DATE OF BIRTH (Month, Day, Year) 12/14/29	
8. BIRTHPLACE (State or Foreign Country) North Carolina							
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE MD				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 2840 W. Garrison Avenue				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Jasper Daniels				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Reaves			
19a. INFORMANT'S NAME (Type/Print) Brenda Williams				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2840 W. Garrison Ave., Balto., MD 21215			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery		DATE 1/2/93		20c. LOCATION — City or Town, State Baltimore Co. MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Blodine W. Ware				22. NAME AND ADDRESS OF FACILITY Wm. C. March F/H, West 4300 Wabash Ave., Baltimore, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gastrointestinal bleeding DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Esophageal Cancer DUE TO (OR AS A CONSEQUENCE OF): Liver Failure - Coagulopathy DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver cirrhosis, Portal hypertension Hepatic encephalopathy							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Fernando Mera, MD				29c. LICENSE NUMBER PG108		29d. DATE SIGNED (Month, Day, Year) 12/29/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO MERA, SINAI HOSPITAL							
31. DATE FILED (Month, Day, Year) DEC 31 1992		32. REGISTRAR'S SIGNATURE J. Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER				2. DATE OF DEATH MONTH 12 DAY 23 YEAR 1992				3. TIME OF DEATH 8:10 P.M.	
4. SOCIAL SECURITY NUMBER 216-36-0700		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-28-40		8. BIRTHPLACE (State or Foreign Country) Burk Co., Ga.	
9a. FACILITY NAME (If not institution, give street and number) 1104 ARGYLE AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH	
10a. STATE Md.				10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore city	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1104 Argyle Ave.				10f. ZIP CODE 21201	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 1 <input type="checkbox"/> Never Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck driver				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Julian White				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mina Scott					
19a. INFORMANT'S NAME (Type/Print) Selena Nadine White				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Argyle Ave. Baltimore Md 21201					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion				20c. LOCATION — City or Town, State 12/30 Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY WM. C. BROWN COMMUNITY FHC 1206 W. NORTH AVE					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) 12/24/1992				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DENNIS CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 10



92 37006

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES ALBERT WATSON, JR <i>James Watson</i>				2. DATE OF DEATH MONTH 12 DAY 27 YEAR 92		3. TIME OF DEATH 1910 M	
4. SOCIAL SECURITY NUMBER 424-70-3662		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-28-51	
8. BIRTHPLACE (State or Foreign Country) Alabama				9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland			
10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 5326 Denmore Avenue			
10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction		15b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) James Albert Watson, Sr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Juanita Miller			
19a. INFORMANT'S NAME (Type/Print) Willie Watson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Luffing Court Essex, Maryland 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem		20c. LOCATION — City or Town, State Balto. CO., MD		20d. DATE 12/27/92	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Maggaleen G. Henson</i>				22. NAME AND ADDRESS OF FACILITY Maggaleen Gilmore Henson Funeral Service c/o Chatman Harris FH 1701 McCulloh St 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Laryngeal Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. consequent hemorrhage DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. esophageal stricture / s/p G-tube placement							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Kimura</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12-27-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hidenao Kimura Sinai Hosp. g Baltimore							
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37007

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PRESTON M. WALTERS				2. DATE OF DEATH MONTH DAY YEAR 12-27-92		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-09-8908		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-1-12	
9a. FACILITY NAME (If not institution, give street and number) 4700 Harford Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE MD				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 4700 Harford Rd				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel			
17. FATHER'S NAME (First, Middle, Last) Curley Monroe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Walters			
19a. INFORMANT'S NAME (Type/Print) Flora Elder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5916 Johnson St./Baltimore, MD 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MD National Cemetery		20c. LOCATION — City or Town, State Laurel, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY WM C. MARCH F.H./1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER 621002		29d. DATE SIGNED (Month, Day, Year) 12-30-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.C. KOWALOWSKI 8604 HARFORD RD BALTO MD 21234							
31. DATE FILED (Month, Day, Year) DEC 31 1992		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7433-510
blh

92 37008

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) David Michael Warne				2. DATE OF DEATH MONTH DAY YEAR 12 28 1992		3. TIME OF DEATH 11:10 PM					
4. SOCIAL SECURITY NUMBER 217-86-3226		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 9, 1965		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH			
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 4417 Holbrook Road				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) Desmond C.C. Warne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine M. Glover							
19a. INFORMANT'S NAME (Type/Print) Connie Warne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4417 Holbrook Rd. Randallstown, Md. 21133							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 12/31/92		DATE 12/31/92		20c. LOCATION — City or Town, State Towson, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Md. 21214							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gunshot wound of Head DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12 28 1992		28b. TIME OF INJURY 8:53 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Subject shot self			
29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER J. Aaron Locke MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12 29 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE Julia Davidson							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2049

28

92 37009

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY WILES				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92		3. TIME OF DEATH 1030 P M	
4. SOCIAL SECURITY NUMBER 216-22-8727		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-13-1927	
8a. FACILITY NAME (If not institution, give street and number) BALTIMORE COUNTY GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN, MD		9c. COUNTY OF DEATH BALTIMORE CO	
10a. STATE Maryland		10b. COUNTY Carroll County		10c. CITY, TOWN OR LOCATION Woodbine		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2598 Route 94				10f. ZIP CODE 21797		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Robert Crabb				18. MOTHER'S NAME (First, Middle, Maiden Surname) Effie Woodard			
19a. INFORMANT'S NAME (Type/Print) Mrs. Reva Mayne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5738 Ridge Rd. Mt. Airy, MD 21771			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) True Gospel Cemetery 1-2-93		20c. LOCATION — City or Town, State Lisbon, MD		20d. DATE 1-2-93	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Ayers				22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE OF INJURY			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER R. H. HOUSE STAFF				29c. LICENSE NUMBER D 40390		29d. DATE SIGNED (Month, Day, Year) 12/29/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P.R. DESAI, M.D. BALTO. COUNTY GEN HOSP, 5401 OLD COURT RD, RANDALLSTOWN, MD 21133							
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE Julia Davidson-Hendall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edith May Kirby Weeks						2. DATE OF DEATH MONTH DAY YEAR December 27, 1992		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216-28-2076		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 22, 1904		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Edenwald, 800 Southerly Road						9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore County	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 800 Southerly Road				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Proprietor		16b. KIND OF BUSINESS/INDUSTRY Wholesale Food Packaging			
17. FATHER'S NAME (First, Middle, Last) Howard S. Kirby				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth May Smith					
19a. INFORMANT'S NAME (Type/Print) Edith May Weeks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Southerly Road, Towson, Maryland 21204					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Mausoleum		DATE		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson				22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd. Timonium, MD 21093					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Dementia DUE TO (OR AS A CONSEQUENCE OF): d. Parkinson's Disease									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 9 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER John D. Milto, M.D.						29c. LICENSE NUMBER D34124		29d. DATE SIGNED (Month, Day, Year) 12/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John D. Milto, M.D. 7600 Osler Drive, Towson, Maryland 21204									
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE John D. Milto					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37011

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lettye Helen Wine				2. DATE OF DEATH MONTH December DAY 28 YEAR 1992		3. TIME OF DEATH 10:30 A.	
4. SOCIAL SECURITY NUMBER 212 22 8555		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 13, 1905	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 511 Charles Street Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE MD.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 511 Charles Street Avenue	
10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Homemaker	
17. FATHER'S NAME (First, Middle, Last) Will May				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Mae Fitzwater			
19a. INFORMANT'S NAME (Type/Print) Alexander Warren Wine				19b. I Roosevelt 2 Roosevelt St., Timonium, Md. 21093 or Rural Route Number, City or Town, State, Zip Code			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens 12/30/92 Timonium, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary				22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, Md. 21093			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert F. O'Donnell				29c. LICENSE NUMBER 209383		29d. DATE SIGNED (Month, Day, Year) 12-28-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter F. O'Donnell, MD - 408 Hesper Drive - 111 Haverhill Rd							
31. DATE FILED (Month, Day, Year) DEC 31 1992				32. REGISTRAR'S SIGNATURE John Davidson-Rodella			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAMIE M YURICK				2. DATE OF DEATH MONTH 12 / DAY 23 / YEAR 1992				3. TIME OF DEATH 10 07 PM							
4. SOCIAL SECURITY NUMBER 212-22-1571		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) 4/03/14		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore					
10a. STATE Maryland				10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 7530 Oakleigh Road						10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Joseph Naidich						18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Unknown									
19a. INFORMANT'S NAME (Type/Print) George M. Yurick						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Scarlett Drive Towson Md 21286									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory				DATE 12/24		20c. LOCATION — City or Town, State Balto. MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Christina A. Kopych						22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Baltimore, MD 21286									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION															
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29a. SIGNATURE AND TITLE OF CERTIFIER Francis T. Khoo STAFF MD						29c. LICENSE NUMBER D30263				29d. DATE SIGNED (Month, Day, Year) 12-23-92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS T. KHOO ST. JOSEPH HOSPITAL															
31. DATE FILED (Month, Day, Year) DEC 31 1992						32. REGISTRAR'S SIGNATURE John Gordon Hordell									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

92 37013

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Donna Viola ADAMS				2. DATE OF DEATH MONTH 12 DAY 18 YEAR 92		3. TIME OF DEATH 6:55 PM	
4. SOCIAL SECURITY NUMBER 235-38-0975		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-25-20	
9a. FACILITY NAME (If not institution, give street and number) LORIE NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH HOWARD	
10a. STATE Maryland				10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Columbia	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6334 Cedar Lane			
10f. ZIP CODE 21044				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Charles H. Huffman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dortha Hale			
19a. INFORMANT'S NAME (Type/Print) Sonja R. Heimlich				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21360 White Pine Road Kildeer, IL 60047			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Washington Crematory		20c. LOCATION — City or Town, State Laurel, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure a. DUE TO (OR AS A CONSEQUENCE OF): Aspiration pneumonia and b. DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive Pulmonary Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease Status Post Cerebrovascular Accident Chronic Schizophrenia					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER D 24721		29d. DATE SIGNED (Month, Day, Year) 12/19/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sgt. A. SABA 14800 4th St, Suite 11A, Laurel, MD 20707							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE DEATH CERTIFICATE IS TO BE COMPLETED BY THE FUNERAL DIRECTOR. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37014

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Adler, CARSON		2. DATE OF DEATH MONTH DAY YEAR 12 30 92		3. TIME OF DEATH 11:00 A M	
4. SOCIAL SECURITY NUMBER 217-20-6993		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 4 20 28		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital & Behnke			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2435 W. BELVEDERE AVE.			10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN		16b. KIND OF BUSINESS/INDUSTRY UNKNOWN	
17. FATHER'S NAME (First, Middle, Last) CHARLES ADLER			18. MOTHER'S NAME (First, Middle, Maiden Surname) CELIA LEVIN		
19a. INFORMANT'S NAME (Type/Print) ALLAN A. ADLER			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6614 DALTON DR BALTO., MD 21207		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BNAI ISRAEL 12/31/92		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Obstructive Pulmonary Disease 10yrs DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Acute Bronchitis DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER D37928		29d. DATE SIGNED (Month, Day, Year) 12/30/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Koss, MD 2435 W. Belvedere Ave Suite 22 Baltimore					
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE 			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				92 37015					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Raymond H. Bennighof				2. DATE OF DEATH MONTH DAY YEAR Dec. 31, 1992				3. TIME OF DEATH 12:30 P. M.					
4. SOCIAL SECURITY NUMBER 215 20 9197		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 3, 1928		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 1910 Stockton Rd.				9b. CITY, TOWN OR LOCATION OF DEATH 21131				9c. COUNTY OF DEATH Baltimore					
RESIDENCE OF DECEDENT													
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Phoenix				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 1910 Stockton Rd.				10f. ZIP CODE 21131				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronics Engineer				16b. KIND OF BUSINESS/INDUSTRY Aerospace					
17. FATHER'S NAME (First, Middle, Last) Cloyd L. Bennighof				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Shearer									
19a. INFORMANT'S NAME (Type/Print) Jane P. Bennighof				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1910 Stockton Rd., Phoenix, Md. 21131									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oakland Cemetery		DATE 1/4/93		20c. LOCATION — City or Town, State Oakland, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson				22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, Md. 21093									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ampullary carcinoma ± lymph node + liver metastasis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval between Onset and Death 1992					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER Alan Kimmel		29c. LICENSE NUMBER D25743		29d. DATE SIGNED (Month/Day/Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Alan L. Kimmel, 220 W. Coldspring Lane, Balto., Md. 21218													
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE John Davidson-Rodell									




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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elton Stewart Becker				2. DATE OF DEATH MONTH DAY YEAR Dec. 29, 1992		3. TIME OF DEATH 8:30 P. M.	
4. SOCIAL SECURITY NUMBER 220 12 8093 A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 20, 1910	
9a. FACILITY NAME (If not institution, give street and number) 12 Queenbridge Court Apt. G				9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Cockeysville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12 Queenbridge Ct. Apt. G				10f. ZIP CODE 21030		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accounting-Book-Keeping		16b. KIND OF BUSINESS/INDUSTRY Esskay Meats-Retail Meat			
17. FATHER'S NAME (First, Middle, Last) William Andrew Becker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Leary Wilderson			
19a. INFORMANT'S NAME (Type/Print) Leonard Joseph Pyecha				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11209 Cedar Lane, Kingsville, Md. 21087			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge		DATE Jan. 2, 1993		20c. LOCATION — City or Town, State Pikesville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Martin D. Lawson				22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, Md. 21093			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC SQUAMOUS CELL CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  JAMES EBELING				29c. LICENSE NUMBER D34827		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. William Ebeling 7401 Osler Drive Towson, Md. 21204							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Franklin BOOTHE JR				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 10:52 A M	
4. SOCIAL SECURITY NUMBER 401 28 0916		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 30, 1924	
9a. FACILITY NAME (If not institution, give street and number) Franklin Sq. Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Abingdon		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2002 Tower Rd.				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver		16b. KIND OF BUSINESS/INDUSTRY Moving and Storage Co.			
17. FATHER'S NAME (First, Middle, Last) John F. Boothe, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Chapman			
19a. INFORMANT'S NAME (Type/Print) Janice E. Boothe, Wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Tower Rd. Abingdon, MD 21001			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Crest Lawn Memorial Gardens 1/4/93		20c. LOCATION — City or Town, State Howard Co., MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Eastern Ave. Balto., MD 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gastrointestinal Acute Bleeding DUE TO (OR AS A CONSEQUENCE OF): b. Severe atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Renal failure DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER P. Baltatzis M.D.				29c. LICENSE NUMBER D 28949		29d. DATE SIGNED (Month, Day, Year) 12-31-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Pannyiotis Baltatzis 1232 Race Rd. Baltimore, Md. 21237							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37018

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BABY GIRL Alexandra BABB				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1992		3. TIME OF DEATH 9:27 A M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS D-YR 0 8		7. DATE OF BIRTH (Month, Day, Year) 12-20-92	
8. BIRTHPLACE (State or Foreign Country) BALTO. Maryland							
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE CITY	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 122 E. Lake Avenue				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Robert Babb				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Gillian O'Brecht			
19a. INFORMANT'S NAME (Type/Print) Peggy O'Brecht				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 St. George Road Baltimore, Maryland 21210			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery		DATE		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John G. Reitz (M-00804)				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Trisomy 13 DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 8 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Lawrence M. Noyce, MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lawrence M. Noyce, MD							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed in the funeral director's office. Page 4 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DANIEL BRYANT				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 1:0A	
4. SOCIAL SECURITY NUMBER 252-36-8662		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-1-26	
8. BIRTHPLACE (State or Foreign Country) GEORGIA				9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Md			
10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION TURNERS STATION			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 413 Chestnut St			
10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONG SHOREMAN		16b. KIND OF BUSINESS/INDUSTRY WATERFRONT			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) BEATRICE BRYANT			
19a. INFORMANT'S NAME (Type/Print) DOLLIE V. BRYANT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Chestnut St Baltimore, Md 21222			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON Forest VA. Cem 1-4-93		20c. LOCATION — City or Town, State OWING MILLS MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton	
22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons		22. NAME AND ADDRESS OF FACILITY Funeral Home 1701 Eastern St		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS ABDOMINAL INFECTION ACUTE MESENTERIC ISCHEMIA ATHEROSCLEROTIC VASCULAR DISEASE			
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Kidney failure Hypertension		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO refused		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO refused		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Kevin A. Rossiter MD attending		29c. LICENSE NUMBER D		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN A. ROSSITER, MD Francis Scott Key Medical Center - B2N 4940 Eastern Ave Baltimore MD 21224							
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE John Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,


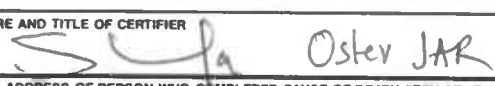
TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIOLA J. BAGBY				2. DATE OF DEATH MONTH DAY YEAR 12 30 1992		3. TIME OF DEATH HOUR MIN AM/PM 3:53 A M	
4. SOCIAL SECURITY NUMBER 193-14-7275		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 70		7. DATE OF BIRTH (Month, Day, Year) 08/12/22	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania							
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE CITY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lansdowne Baltimore City		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 119 Hazel Avenue				10f. ZIP CODE 3300 Benson Ave., Apt. 312 21227		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier		16b. KIND OF BUSINESS/INDUSTRY Food			
17. FATHER'S NAME (First, Middle, Last) Meade Barnett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ora Truax			
19a. INFORMANT'S NAME (Type/Print) John F. Bagby				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Hazel Avenue, lansdowne, Maryland 21227			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Ceme. 01/05/93 Garrison Forest, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home of Lansdowne 2719 Hammonds Fr. Rd. Lansdowne, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. MYOCARDIAL INFARCTION				Approximate Interval Between Onset and Death 2-3 hours	
		b. CARDIOGENIC SHOCK				2-3 hours	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECENT PERFORATION OF SIGMOID COLON							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) CCU					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Oster JAR					
		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/30/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANJAY KHANDUJA, TOWER 110 JOHNS HOPKINS HOSPITAL, BALTIMORE, MD							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				92 37021					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) FRANK RAYMOND BEEFELT				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 92				3. TIME OF DEATH 11:00 P M					
4. SOCIAL SECURITY NUMBER 212-05-5627		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		7. DATE OF BIRTH (Month, Day, Year) 12-12-05		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH N/A					
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 442 S. Smallwood St. - Baltimore, Md.				10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance				15b. KIND OF BUSINESS/INDUSTRY Balto. Gas Co.							
17. FATHER'S NAME (First, Middle, Last) Raymond E. Beefelt				18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara A. Peschaut									
19a. INFORMANT'S NAME (Type/Print) Mrs. Evelyn Baumgardner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 442 S. Smallwood St. - Baltimore, Md. 21223									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 12-31-92		20c. DATE 12-31-92		20d. LOCATION — City or Town, State Baltimore, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab				22. NAME AND ADDRESS OF FACILITY 3512 Frederick Avenue Baltimore, Md. 21229									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAC ARREST IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST ELECTROLYTES IMBALANCE CHRONIC RENAL FAILURE										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPSIS										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MEDICAL RESIDENT				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 12/28/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TIN DO MAUNG ST AGNES HOSPITAL													
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE [Signature]									

92 37022

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOYCE BOYETTE				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 08:38A	
4. SOCIAL SECURITY NUMBER 215-50-4804		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	7. DATE OF BIRTH (Month, Day, Year) 6-4-1948		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) University Hospital				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
10a. STATE MD				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 403 POPLAR GROVE ST.		10f. ZIP CODE 21223	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) CLARENCE JONES SR.	
18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS STANLEY				19a. INFORMANT'S NAME (Type/Print) DORIS JONES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 POPLAR GROVE ST. BALTO. MD 21223	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 1-5-93		20c. LOCATION - City or Town, State Randallstown, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Phyllis B. Scott				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME - WEST 4300 WABASH AVE. BALTO. MD 21215		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diabetic Ketoacidosis DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 21 S Green Street Balto Md 21201				31. DATE FILED (Month, Day, Year) JAN 4 1993			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13-1



92 37023

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Reannuiced

1. DECEDENT'S NAME (First, Middle, Last) LEROY BOLLING				2. DATE OF DEATH 12-26-92 MONTH DAY YEAR 12 26 92		3. TIME OF DEATH 3:50 PM	
4. SOCIAL SECURITY NUMBER 129-20-0378		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/27/27	
8. BIRTHPLACE (State or Foreign Country) Richmond, VA				9. CITY, TOWN OR LOCATION OF DEATH Aberdeen		10. COUNTY OF DEATH Harford	
11. FACILITY NAME (If not institution, give street and number) 754 Battle Avenue				12. CITY, TOWN OR LOCATION OF DEATH Aberdeen		13. COUNTY OF DEATH Harford	
14a. STATE Maryland		14b. COUNTY Harford County		14c. CITY, TOWN OR LOCATION Aberdeen		14d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
15. STREET AND NUMBER 754 Battle Avenue				16. ZIP CODE 21001		17. CITIZEN OF WHAT COUNTRY? USA	
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Yes		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: Black	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		24. KIND OF BUSINESS/INDUSTRY			
25. FATHER'S NAME (First, Middle, Last)				26. MOTHER'S NAME (First, Middle, Maiden Surname)			
27. INFORMANT'S NAME (Type/Print) PerryPtHosp (VA)				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
29. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		31. LOCATION — City or Town, State			
32. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir <i>Ronald Wade</i> 12/30/92				33. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic Cardiovascular</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							35. Approximate Interval Between Onset and Death Years
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							37. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
38. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
39. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		40. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
41. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		42. 28a. DATE OF INJURY (Month, Day, Year)		43. 28b. TIME OF INJURY M		44. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
45. 28d. DESCRIBE HOW INJURY OCCURRED		46. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		47. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
48. 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
49. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard J. Colfer, M.D.</i> Richard J. Colfer, M.D.				50. 29c. LICENSE NUMBER DO 1194		51. 29d. DATE SIGNED (Month, Day, Year) 12/26/92	
52. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2013 Tangle Creek Rd Baltimore, Md. 21034							
53. 31. DATE FILED (Month, Day, Year) JAN 4 1993		54. 32. REGISTRAR'S SIGNATURE <i>John Benison-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 10e; film g-695;1-22-93; dr

ITEMS: 23 PART I,27,28a,b,c,d,e,f PER MEO G-695 1/8/93 reb

92 37024

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENNETH Dean COOKE				2. DATE OF DEATH MONTH 12 DAY 22 YEAR 92		3. TIME OF DEATH 10:09 A.	
4. SOCIAL SECURITY NUMBER 455-84-4756		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-9-1951	
8. BIRTHPLACE (State or Foreign Country) Colorado							
9a. FACILITY NAME (If not institution, give street and number) #8 JEFFERSON STREET				9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 18005 Fertile Meadow Court				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chaplin		16b. KIND OF BUSINESS/INDUSTRY Adventest Hospital			
17. FATHER'S NAME (First, Middle, Last) Robert Franklin Cooke, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wanda Eiland			
19a. INFORMANT'S NAME (Type/Print) Wanda Cooke				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4741 Dorsey Street Fort Worth, Texas 76119			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Keene Community Cemetery		DATE 12/22/92		20c. LOCATION — City or Town, State Keene, Texas	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE DRUG INTOXICATION DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? X YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 12/22/92		28b. TIME OF INJURY 9:35 A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT INGESTED DRUGS		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 JEFFERSON ST. TAKOMA PARK, MARYLAND			
29a. CERTIFIER (Check only) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 					
		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12-23-1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. L. Lake, MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37025

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph Cudnik				2. DATE OF DEATH December 25, 1992				3. TIME OF DEATH 12:50 P M			
4. SOCIAL SECURITY NUMBER 218-05-9487		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-20-12		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 601 S. CURLEY STREET				10f. ZIP CODE 21224				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 YEARS College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BAKER				16b. KIND OF BUSINESS/INDUSTRY MD. STATE			
17. FATHER'S NAME (First, Middle, Last) FRANK CUDNIK						18. MOTHER'S NAME (First, Middle, Maiden Surname) STELLA MICHALAK					
19a. INFORMANT'S NAME (Type/Print) MS. DAWN CUDNIK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 BEAR RIDGE RD. APT 2 BALTO 21222							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY ROSARY CEMETERY				20c. LOCATION — City or Town, State 12-28 BALTO. CO. MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond J. Kaczorowski</i>						22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):											
b. Sepsis DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Arkie</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12-25-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Arkie, M.D. c/o Maryland General Hospital											
31. DATE FILED (Month, Day, Year) JAN 4 1993											
32. REGISTRAR'S SIGNATURE <i>Julia Arkie</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				92 37026			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
HARRY COHN				DEC 27 1992				11:00AM			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
579-18-6395		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		89 YRS.		Aug 27, 1903		NEW JERSEY			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
6700 BELCREST ROAD #52 B				HYATTSVILLE				PRINCE GEORGE'S			
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
MARYLAND				PRINCE GEORGE'S		HYATTSVILLE		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
6700 BELCREST ROAD #52 B				20782				U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: WHITE					
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 5+)				LAWYER				LAW			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
NATHAN COHN				IDA APPLESTEIN							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
LILLIAN HOLOBER				12601 BLACKWELL LANE, BOWIE, MARYLAND 20715							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		JUDAN MEMORIAL GARDENS		12/29/92		OLNEY, MARYLAND					
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Donald C. Stottlemeyer				STEIN HEBREW MEMORIAL FUNERAL HOME, INC.							
				232 CARROLL STREET, NW, WASHINGTON, DC							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								Acute			
a. CARDIOVASCULAR ACCIDENT											
DUE TO (OR AS A CONSEQUENCE OF):											
b. ATHEROSCLEROSIS, ASHD								years.			
DUE TO (OR AS A CONSEQUENCE OF):											
c. PERIPHERAL VASCULAR INSUFFICIENCY											
DUE TO (OR AS A CONSEQUENCE OF):											
d.											
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?			
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE NOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER							
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				J. BERGER MD							
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER							
				D25925							
				29d. DATE SIGNED (Month, Day, Year)							
				Dec 27, 1992							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)							
J. BERGER MD, #205, 7720 Wisconsin Ave, Bethesda Md 20814				JAN 4 1993							

1947

2004-04-14

92 37027

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michael H. CHEERS JR.				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 9:05 A	
4. SOCIAL SECURITY NUMBER 215-01-5862		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-22-1901	
8. BIRTHPLACE (State or Foreign Country) MD.				9a. FACILITY NAME (If not institution, give street and number) MED-BRIDGE N.H.		9b. CITY, TOWN OR LOCATION OF DEATH ESSEX	
9c. COUNTY OF DEATH BALTO. CO.				10a. STATE MD.		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1107 S. ROBINSON ST.	
10f. ZIP CODE 21224				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) IRON WORKER		16b. KIND OF BUSINESS/INDUSTRY IRON	
17. FATHER'S NAME (First, Middle, Last) MICHAEL H. WISENIEWSKI				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) JAMES HOLDEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 MARGARET AVE. BALTO. MD. 21221			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EBENEZER UN. METH CH 1-2-93		20c. LOCATION — City or Town, State BALTO. CO. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phonoff Skarda Jr.</i>				22. NAME AND ADDRESS OF FACILITY HOFFMAN-SKARDA F.H. 3218 HUDSON ST. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Aspiration Pneumonia Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. Olaner</i>				29c. LICENSE NUMBER D30641		29d. DATE SIGNED (Month, Day, Year) 12/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROMESA SABARWAL Suite 308 821 N. Eutan CT BALTIMORE MD 21201							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37028

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Russell Dasher				2. DATE OF DEATH 12-29-92		3. TIME OF DEATH 1:30 PM	
4. SOCIAL SECURITY NUMBER 021-20-9681		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-6-1928	
9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL CORPORATION				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH na	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 227S. Broadway				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 12/30/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Great cell carcinoma of kidney with metastases to lung & bone. b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death Unknown
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Victor Ankoma-Sey MD				29c. LICENSE NUMBER D42737		29d. DATE SIGNED (Month, Day, Year) 12-29-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) VICTOR ANKOMA-SEY MD, 100 NORTH BROADWAY ST. BALTIMORE, MD 21231							
31. DATE FILED (Month, Day, Year) 12 JAN - 4 1993		32. REGISTRAR'S SIGNATURE Jane Benbow-Rubell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

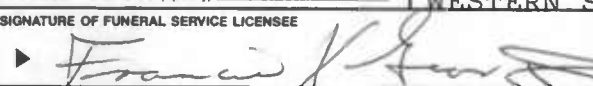


DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37029

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROOSEVELT EVANS				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92				3. TIME OF DEATH M		
4. SOCIAL SECURITY NUMBER 212-58-6481		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		
7. DATE OF BIRTH (Month, Day, Year) 4-29-53				8. BIRTHPLACE (State or Foreign Country) MD						
9a. FACILITY NAME (If not institution, give street and number) 131 LINDEN CT.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH		
10a. STATE MD			10b. COUNTY			10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 131 LINDEN CT.				10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION		
17. FATHER'S NAME (First, Middle, Last) ROOSEVELT EVANS				18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCES MITCHELL						
19a. INFORMANT'S NAME (Type/Print) FRANCES EVANS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 LINDEN CT./BALTIMORE, MD 21222						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY				20c. LOCATION — City or Town, State CATONSVILLE, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Stage IV Lung Cancer a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER 027938				29d. DATE SIGNED (Month, Day, Year) 12/31/92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mayer Gorbatsky 795 Aquahart Road Glen Burnie MD										
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STANDARD

SECTION

10/1/1911

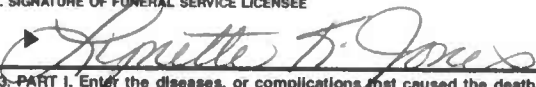
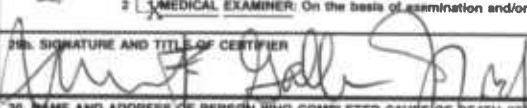
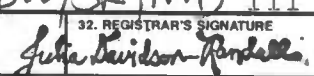
92-7434-510
blh

92-249

92 37030

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sanford Ford				2. DATE OF DEATH MONTH DAY YEAR 12 28 1992		3. TIME OF DEATH 11:35 P M			
4. SOCIAL SECURITY NUMBER 217-14-0118		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 20 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-13-72		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) 900 blk. W. Saratoga Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH	
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2122 CLIFTWOOD AVENUE				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) SANFORD B. FORD, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) RUTH A. PARKER					
19a. INFORMANT'S NAME (Type/Print) RUTH A. FORD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 CLIFTWOOD AVE./BALTIMORE, MD 21213					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHELL MEMORIAL GARDENS		DATE		20c. LOCATION — City or Town, State DUNDALK, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND TO BACK OF CHEST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) on street							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12 28 1992		28b. TIME OF INJURY 11:35 P M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Subject shot	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) on street				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 900 blk. W. Saratoga St.					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  MARIO F. GOLUB, JR., MD						29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) 12 29 1992						29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLUB, JR., MD 111 Penn Street, Baltimore, Maryland 21201			
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE 							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37031

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FOOTE, WILLIAM B.				2. DATE OF DEATH MONTH DAY YEAR DEC 31, 1992				3. TIME OF DEATH 1:58PM M	
4. SOCIAL SECURITY NUMBER 197-03-6400		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-16-19		8. BIRTHPLACE (State or Foreign Country) Penna.	
9a. FACILITY NAME (If not institution, give street and number) VA Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point				9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 924 Ashbridge Drive				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Letter Carrier			16b. KIND OF BUSINESS/INDUSTRY Postal Service			
17. FATHER'S NAME (First, Middle, Last) William B. O. Foote				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Copple					
19a. INFORMANT'S NAME (Type/Print) Emma Jane Foote				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Ashbridge Dr. Balto., MD 21221					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 1/2/93		DATE 1/2/93		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Eastern Ave. Balto. MD 21221					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D16608		29d. DATE SIGNED (Month, Day, Year) 12-31-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KAM KEN LEUNG, M.D., VAMC PERRY POINT, MD 21902									
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 4 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1947

1. The first part of the report is devoted to a general survey of the situation in the country. It is followed by a detailed analysis of the economic and social conditions. The third part of the report is devoted to a study of the political situation. The fourth part of the report is devoted to a study of the cultural situation. The fifth part of the report is devoted to a study of the educational situation. The sixth part of the report is devoted to a study of the health situation. The seventh part of the report is devoted to a study of the housing situation. The eighth part of the report is devoted to a study of the transportation situation. The ninth part of the report is devoted to a study of the communication situation. The tenth part of the report is devoted to a study of the environment situation. The eleventh part of the report is devoted to a study of the security situation. The twelfth part of the report is devoted to a study of the foreign relations situation. The thirteenth part of the report is devoted to a study of the international situation. The fourteenth part of the report is devoted to a study of the world situation. The fifteenth part of the report is devoted to a study of the future situation. The sixteenth part of the report is devoted to a study of the past situation. The seventeenth part of the report is devoted to a study of the present situation. The eighteenth part of the report is devoted to a study of the future situation. The nineteenth part of the report is devoted to a study of the past situation. The twentieth part of the report is devoted to a study of the present situation.

92 37032

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Frey WILLIAM LESTER FREY				2. DATE OF DEATH MONTH DAY YEAR 12/30/92		3. TIME OF DEATH 9:15 P M	
4. SOCIAL SECURITY NUMBER 219-20-0289		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67-6 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/26/25	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
10a. STATE MD				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 132 S. Collins Ave.		10f. ZIP CODE 21229	
10g. CITIZEN OF WHAT COUNTRY? US				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1945-1948	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 7 N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembler		16b. KIND OF BUSINESS/INDUSTRY Lock Insulator	
17. FATHER'S NAME (First, Middle, Last) William Frey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leila-Lia-Porter			
19a. INFORMANT'S NAME (Type/Print) Lois Frey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 S. Collins Ave., Balto., Md. 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Jennings Chapel Cem. 1-2-93		20c. LOCATION — City or Town, State Howard Co., MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab				22. NAME AND ADDRESS OF FACILITY 5151 Baltimore National Pike Baltimore, Md. 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Primary Biliary Cirrhosis							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A.H. Guarino M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.H. Guarino, Sinai Hospital							
31. DATE FILED (Month, Day, Year) JAN 14 1993				32. REGISTRAR'S SIGNATURE John Burdon-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37033

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRED J FRIEL, JR				2. DATE OF DEATH MONTH 12 DAY 24 YEAR 92		3. TIME OF DEATH 07:25 PM	
4. SOCIAL SECURITY NUMBER 150 10 8856		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-17-1912	
8a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				8b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		8c. COUNTY OF DEATH A.A. COUNTY	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6921 Baltimore/Annapolis Blvd				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) Atty Bruce Chapper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> 12/29/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bone Marrow Failure DUE TO (OR AS A CONSEQUENCE OF): b. Malnutrition DUE TO (OR AS A CONSEQUENCE OF): c. Renal Insufficiency DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Progressive Dementia Recurrent urinary tract infections							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attending MD</i>				29c. LICENSE NUMBER D41927		29d. DATE SIGNED (Month, Day, Year) 12/26/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JORGE PEREZ-ALARD, M.D./3708 MOUNTAIN ROAD/PASADENA, MARYLAND 21122							
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE <i>John Sanders</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37034

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Ford				2. DATE OF DEATH MONTH DAY YEAR 12 30 92		3. TIME OF DEATH 1150 P M	
4. SOCIAL SECURITY NUMBER 212-44-4700		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 15 1947	
9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6 Caleta Place				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yr				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LPN Nurse		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Ralph Scott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jan Kelly			
19a. INFORMANT'S NAME (Type/Print) George Yoder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Caleta Place Baltimore Md. 21220			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 1/4/92		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome 300MaceAve. 21221			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P Radiation therapy							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan Denman</i>				29c. LICENSE NUMBER D 23584		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S Denman 5505 Hopkins Bayview Circle Balt Md 21224							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1st of July 1864
Dear Sir
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the above named matter.

Very respectfully,
Your obedient servant,
J. M. Smith

Enclosed find the same as before.

Very respectfully,
Your obedient servant,
J. M. Smith
J. M. Smith
J. M. Smith

92 37035

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth B. Green				2. DATE OF DEATH MONTH Dec DAY 28 YEAR 1992		3. TIME OF DEATH 10:30 P.M.	
4. SOCIAL SECURITY NUMBER 213-20-1248		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	7. DATE OF BIRTH (Month, Day, Year) 8-10-19	8. BIRTHPLACE (State or Foreign Country) MD		
9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4305 Wakefield Rd.				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (14 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Baltimore City Hospital			
17. FATHER'S NAME (First, Middle, Last) Samuel Dorsey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Jones Dorsey			
19a. INFORMANT'S NAME (Type/Print) Mrs. Doris Dorsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1929 Druid Hill Ave./Baltimore, MD 21217			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National Cem.		20c. LOCATION — City or Town, State Baltimore, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM C. MARCH F.H./1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D.				29c. LICENSE NUMBER D41365		29d. DATE SIGNED (Month, Day, Year) Dec 28, 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. Liberty Medical Center.							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				92 37036	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) HERMAN LEWIS GORDON				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 23, 1992				3. TIME OF DEATH 12:00 P M	
4. SOCIAL SECURITY NUMBER 579-32-8767		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 30, 1912		8. BIRTHPLACE (State or Foreign Country) NEW HAMPSHIRE	
9a. FACILITY NAME (If not institution, give street and number) 306 ELSEWORTH DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING				9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 306 ELSEWORTH DRIVE				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAWYER		16b. KIND OF BUSINESS/INDUSTRY PRIVATE LAW					
17. FATHER'S NAME (First, Middle, Last) RAPHEL GORDON				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH HOFFMAN					
19a. INFORMANT'S NAME (Type/Print) SARA GORDON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 ELSEWORTH DRIVE, SILVER SPRING, MARYLAND 20910					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) KING DAVID MEMORIAL GARDEN 12-24-92		20c. LOCATION — City or Town, State FALLS CHURCH, VIRGINIA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stettin				22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, DC					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION a. DUE TO (OR AS A CONSEQUENCE OF): b. PARKINSONISM c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER HAMMETT MD				29c. LICENSE NUMBER D39966	
29d. DATE SIGNED (Month, Day, Year) 12/23/92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CAROLYN A. HAMMETT 6111 EXECUTIVE BLVD ROCKVILLE, MD					
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE John Davidson					

92 37037

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rosetta Glashofer (ROSSETTA A. F. GLASHOFER)				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 92		3. TIME OF DEATH 1038 P M	
4. SOCIAL SECURITY NUMBER 293-12-7691		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/27/1903	
8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3900 N. CHARLES ST., APT. 607				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY EDUCATION			
17. FATHER'S NAME (First, Middle, Last) JOSEPH FELDMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNIE BEARMAN			
19a. INFORMANT'S NAME (Type/Print) MISS SADIE FELDMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 N. CHARLES ST., APT. 814 BALTO., MD 21218			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW FRIENDSHIP 12/31/92		20c. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. MYOCARDIAL INFARCTION					Approximate Interval Between Onset and Death hours
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12/28/92		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER 042713		29d. DATE SIGNED (Month, Day, Year) 12/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TOWSON MEMORIAL HOSPITAL BALTO MD							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37038

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES W. HOWARD				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 255 64 9048		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-28-45	
8. BIRTHPLACE (State or Foreign Country) GA				9a. FACILITY NAME (If not institution, give street and number) Howard Co. Gen Hosp		9b. CITY, TOWN OR LOCATION OF DEATH Columbia MD	
9c. COUNTY OF DEATH HOWARD				10a. STATE MD		10b. COUNTY HOWARD	
10c. CITY, TOWN OR LOCATION Columbia				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9433 Macomber Lane	
10f. ZIP CODE 21045				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs College (1-4 or 5+) Computer Consultant				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Firm		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) James F. Howard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ola King			
19a. INFORMANT'S NAME (Type/Print) Jacqueline Howard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9433 Macomber Lane Columbia Md. 21045			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Myrtle Hill Cemetery 1-593 Rome, GA.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Glynnis B. Scott				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME - WEST 4300 Wabash Ave. Balt. Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of Colon Stage 2 DUE TO (OR AS A CONSEQUENCE OF): Liver metastasis DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER MD.			
29c. LICENSE NUMBER D 27565				29d. DATE SIGNED (Month, Day, Year) 12/31/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NANAVATI A. 1600 Union Highway Glenburne 21061							
31. DATE FILED (Month, Day, Year) JAN 31 1993				32. REGISTRAR'S SIGNATURE G. Henderson-Randall			

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10

errata

92 37039

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WANDA LOUISE HUNDERTMARK HUNDERTMARK, WANDA LOUISE			2. DATE OF DEATH MONTH DAY YEAR 12 30 92		3. TIME OF DEATH 5:45 A M								
4. SOCIAL SECURITY NUMBER 282-22-9152		6. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 15 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-12-27		8. BIRTHPLACE (State or Foreign Country) W. Virginia					
9a. FACILITY NAME (If not institution, give street and number) LORIE FRANKFORD NC				9b. CITY, TOWN OR LOCATION OF DEATH BALTO CITY			9c. COUNTY OF DEATH na						
10a. STATE MD			10b. COUNTY na			10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER LorienFrankford NurCent 5009FrankfordAve						10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES no			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Omer Baker						18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Jeffries							
19a. INFORMANT'S NAME (Type/Print) Pauline cook						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1215 Gusryan Street, Baltimore, MD 21224							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 12/30/92						22. NAME AND ADDRESS OF FACILITY StateAnatomyBoard 655 W. Baltimore Street, Balto, MD 21201							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic large cell carcinoma of lung DUE TO (OR AS A CONSEQUENCE OF): b. H/O CAD DUE TO (OR AS A CONSEQUENCE OF): c. H/O COPD DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Attending Physician				29c. LICENSE NUMBER D 28461		29d. DATE SIGNED (Month, Day, Year) 12-30-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard Bennett MD 5505 Hopkins Bayview Balto MD 21224													
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE John S. ...									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

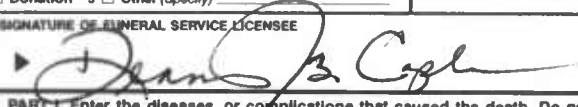
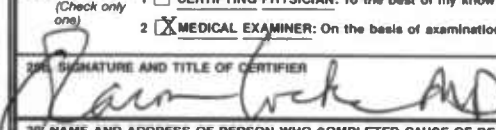
92-7465-510

ML, Jr.

92 37040

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Milton Johnson				2. DATE OF DEATH MONTH DAY YEAR 12 29 1992		3. TIME OF DEATH 3:24	
4. SOCIAL SECURITY NUMBER 218-01-1765		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-09-1915	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. CITIZEN OF WHAT COUNTRY? USA	
10f. STREET AND NUMBER 5220 York Road Apt. 11F				10g. ZIP CODE 21212		10h. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 11/19/42 10/20/45		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Feed Company	
17. FATHER'S NAME (First, Middle, Last) Edgar Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Liddy Tate			
19a. INFORMANT'S NAME (Type/Print) Sheila Gasque				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Walters Ave. Baltimore, Md. 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Garrison Forest 1/04/93		20c. LOCATION — City or Town, State Owings Mills, Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Dennis B. Caple F.S. 2654 Maryland Ave. Balto, Md. 21218				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Inquiry		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12 29 1992	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER  J. Laron Locke, MD.				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12 30 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Laron Locke, MD. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text

Page 10

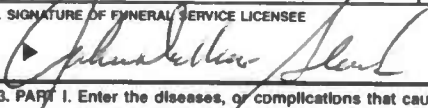
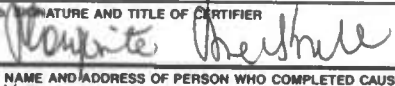
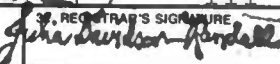
92-7465-510
M.L., Jr.

92 37041

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Terry Donnell Knocket				2. DATE OF DEATH MONTH DAY YEAR 12 30 1992		3. TIME OF DEATH 9:35 P M			
4. SOCIAL SECURITY NUMBER 218-66-2018		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-17-1965		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH -----		
10a. STATE Maryland				10b. COUNTY Howard County		10c. CITY, TOWN OR LOCATION Columbia		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9469 Latchkey Row				10f. ZIP CODE 21045		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Barber		16b. KIND OF BUSINESS/INDUSTRY Hair Salon/Barber Shop					
17. FATHER'S NAME (First, Middle, Last) Willie Knocket				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wisteen Ned					
19a. INFORMANT'S NAME (Type/Print) Ms. Wisteen Knocket				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9469 Latchkey Row, Columbia, MD 21045					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Columbia Mem. Pk. 1-5-93		DATE 1-5-93		20c. LOCATION — City or Town, State Columbia, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00535				22. NAME AND ADDRESS OF FACILITY Slack Funeral Home Ellicott City, Maryland 21043					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF CHEST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12 30 1992		28b. TIME OF INJURY 9:16 P M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Subject shot	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) on street				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2300 blk E Biddle Street					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12 31 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Koron, M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. DATE JAN 4 1993		32. REGISTRAR'S SIGNATURE 							



92 37042

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH KANDEL				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 1992				3. TIME OF DEATH 10:04 AM	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 10, 1903		8. BIRTHPLACE (State or Foreign Country) RUSSIA	
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH	
10a. STATE MARYLAND				10b. COUNTY				10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3601 FORDS LANE, APT. 303				10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOUSEWIFE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE				16b. KIND OF BUSINESS/INDUSTRY AT HOME	
17. FATHER'S NAME (First, Middle, Last) MAX TAYLOR				18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA					
19a. INFORMANT'S NAME (Type/Print) MR JERRY KANDEL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 TEMPLECLIFF RD. BALTO., MD 21208					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WORKMEN CIRCLE - 12-30-92 BALTIMORE, MD				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA, CHF Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Aortic valvular disease a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Rama Shankar MD				29c. LICENSE NUMBER	
29d. DATE SIGNED (Month, Day, Year) 12/28/92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) RAMA SHANKAR SINAI HOSP OF BALTIMORE					
31. DATE FILED (Month, Day, Year) JAN 2/4 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

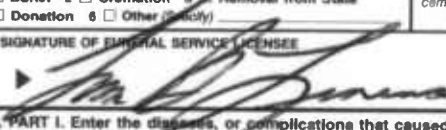
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24. 5. 1901

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEDENT'S NAME (First, Middle, Last) ARLENE LEVITAS				2. DATE OF DEATH MONTH DAY YEAR 12/29/92		3. TIME OF DEATH 10:00 P					
4. SOCIAL SECURITY NUMBER 217-20-5776		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8/5/1927		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH				
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 6701 PARK HEIGHTS AVE., APT. 3-C				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SINGER		16b. KIND OF BUSINESS/INDUSTRY CHOIR							
17. FATHER'S NAME (First, Middle, Last) BENJAMIN COHEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVA GLASS							
19a. INFORMANT'S NAME (Type/Print) REUBEN LEVITAS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 PARK HEIGHTS AVE., APT. 3-C BALTO., MD 21215							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) BETH EL MEMORIAL PARK 12/31/92		20c. LOCATION — City or Town, State RANDALLSTOWN, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Gastric Ca mets, Hypotension, DUE TO (OR AS A CONSEQUENCE OF): b. Electrolyte Imbalance DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Rama Shankar						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/29/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAMA SHANKAR SINAI HOSP. OF BALTIMORE											
31. DATE FILED (Month, Day, Year) JAN 24 1993											

92 37044

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STELLA LINDE				2. DATE OF DEATH MONTH DAY YEAR DEC. 29, 1992		3. TIME OF DEATH 11:40 A M	
4. SOCIAL SECURITY NUMBER 220-92-7521		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/8/1918	
8. BIRTHPLACE (State or Foreign Country) SOUTH AFRICA				9a. FACILITY NAME (If not institution, give street and number) 7302 PARK HEIGHTS AVE., APT. C		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH							
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7302 PARK HEIGHTS AVE., APT. C				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) ARTHUR ISAACSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MIRIAM NORMAN			
19a. INFORMANT'S NAME (Type/Print) MR. SOLLY LINDE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7302 PARK HEIGHTS AVE., APT. C BALTO., MD 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH JACOB 12/30/92		DATE 20c. LOCATION — City or Town, State FINKSBURG, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay Alay Lewis</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CARCINOMA TO LUNG, LIVER DUE TO (OR AS A CONSEQUENCE OF): b. RIGHT LUNG CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): c. <i>E</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 MINIX 8 mos
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMA & CHRONIC BRONCHITIS RENAL INSUFFICIENCY DIABETES MELLITUS							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Harrison MD</i>				29c. LICENSE NUMBER D12942		29d. DATE SIGNED (Month, Day, Year) 12/29/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) JAN 4 1993							
REGISTRAR SIGNATURE <i>Julia Harrison</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1974-75

1974-75

21050 80

1. 1951 - 1952

1953

1954 - 1955

1956 - 1957

1958 - 1959

1960 - 1961

1962

1963 - 1964

1965 - 1966

1967 - 1968

Handwritten signature

EDWIN S. JAMES

20050 98

[Faint handwritten signature]

[Faint handwritten signature] 2001 3 11/01



92 37047

ITEMS: 23 PART I, II, 27, 28a, b, f PER MEQ G-695 1/14/93 reb

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARC IRA LUCKMAN				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92		3. TIME OF DEATH 8:15 A.M.	
4. SOCIAL SECURITY NUMBER 216-52-6432		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 26, 1956	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 11 GWYNN MILLS COURT		9b. CITY, TOWN OR LOCATION OF DEATH OWINGS MILLS	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1335 SUDVALE RD.	
10f. ZIP CODE 21208				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CPA				16b. KIND OF BUSINESS/INDUSTRY ACCOUNTING			
17. FATHER'S NAME (First, Middle, Last) SAMUEL LUCKMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) BEATRICE BECKER			
19a. INFORMANT'S NAME (Type/Print) MRS. MICHELLE LUCKMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1335 SUDVALE RD. BALTO., MD 21208			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) BETH EL MEM. PARK 12.31/92			
20c. LOCATION — City or Town, State RANDALLSTOWN, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellenue Levinson			
22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARBON MONOXIDE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DRUG ABUSE				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 11 GWYNN MILLS CT				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year) 12-29-1992				28b. TIME OF INJURY FOUND M 3:09 A			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED SUBJECT INHALED AUTO EXHAUST FUMES			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) IN AUTO				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 11 GWYNN MILLS COURT			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golie, Jr.				29c. LICENSE NUMBER O.C.M.E.			
29d. DATE SIGNED (Month, Day, Year) 12-29-1992				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) MARIO F. GOLIE, JR. 111 Penn Street, Baltimore, Maryland 21201			
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. SIGNATURE OF REGISTRAR John H. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37048

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THELMA MCHONEY				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1992				3. TIME OF DEATH 2:08 P M	
4. SOCIAL SECURITY NUMBER 217-16-4635		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-5-24		8. BIRTHPLACE (State or Foreign Country) S.C.	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MD				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1201 N. Luzerne Ave.				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Packer		16b. KIND OF BUSINESS/INDUSTRY MD Cup Company			
17. FATHER'S NAME (First, Middle, Last) Edward McHoney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Richardson					
19a. INFORMANT'S NAME (Type/Print) Marsha McHoney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 N. Luzerne Ave./Baltimore, MD 21213					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park		20c. LOCATION — City or Town, State Randallstown, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM C. MARCH F.H./1101 E. NORTH AVE.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 4-6 hours unknown yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12/28/92		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED No Injury	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER R. Hope MD F9470		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital Emergency Room Baltimore, MD									
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37049

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Blanche Marguerite McAndrews				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 92		3. TIME OF DEATH 1:00 AM					
4. SOCIAL SECURITY NUMBER 215-38-8982		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 1 1914		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Cockeysville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 303 Limestone Valley Drive, Apt. E				10f. ZIP CODE 21030		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) US Army Nurse			16b. KIND OF BUSINESS/INDUSTRY US Army					
17. FATHER'S NAME (First, Middle, Last) Martin Wayne Sagner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Agnes Aberts							
19a. INFORMANT'S NAME (Type/Print) Mrs. Irest Mathis			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 258 Pertch Rd., Severna Park, MD 21146								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cemetery 12/31 Garrison, MD			20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson			22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, MD 21093								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of the Lung DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Eddie Nakhuda					29c. LICENSE NUMBER 915404		29d. DATE SIGNED (Month, Day, Year) 12-28-92				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Eddie Nakhuda - Stella Maris Hospice											
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE Julie Davidson-Randall									

M. L. JR.

92 37050

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92				3. TIME OF DEATH 5:54 P.	
4. SOCIAL SECURITY NUMBER 216-84-5870		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-13-64		8. BIRTHPLACE (State or Foreign Country) Batto. Md	
9a. FACILITY NAME (If not institution, give street and number) S.T.U.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Batto. City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1021 W. LEXINGTON ST				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Joseph Milligan SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Shirley A Milligan					
19a. INFORMANT'S NAME (Type/Print) Shirley A. Milligan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 W LEXINGTON ST, BATTI, MD 21223					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARDBURY MEM PK		DATE		20c. LOCATION — City or Town, State Batto, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY WM C. BREWEN COMMUNITY F/H 1206 W. NORTH AVE					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF HEAD; GUNSHOT WOUND TO									
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. RIGHT SHOULDER									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12/28/92		28b. TIME OF INJURY 11:35P		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Subject shot during robbery	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 901 W. SARA TOGA STREET					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/31/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARRISON D. KOBAN 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


02.11.95

[Faint handwritten text]

92 37051

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BETTY ANNE MORIN				2. DATE OF DEATH MONTH 12 DAY 26 YEAR 92				3. TIME OF DEATH 10:55 AM					
4. SOCIAL SECURITY NUMBER 031-22-8385		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 19, 1928		8. BIRTHPLACE (State or Foreign Country) MASSACHUSETTS					
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA				9c. COUNTY OF DEATH MONTGOMERY					
10a. STATE VIRGINIA				10b. COUNTY FAIRFAX		10c. CITY, TOWN OR LOCATION McLEAN				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 7305 LINGANORE COURT				10f. ZIP CODE 22102				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE				16b. KIND OF BUSINESS/INDUSTRY NA					
17. FATHER'S NAME (First, Middle, Last) RICHARD M. KANE						18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH A. LUCEY							
19a. INFORMANT'S NAME (Type/Print) JAMES B. MORIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7305 LINGANORE CT McLEAN VA 22102									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEM. 12/92				20c. LOCATION — City or Town, State ARLINGTON, VA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MURPHY'S FALLS CHURCH FH, INC. 1102 W. BROAD ST FALLS CHURCH, VA 22046									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER MELISSA A. MASQUELIER, MD				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 12/26/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHERRY KROLL, MD. NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20859													
31. DATE FILED (Month, Day, Year) JAN 4 1993													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Mar 1956



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92 37052

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMMA ELIZABETH MELDROM				2. DATE OF DEATH MONTH DAY YEAR 12 24 1992		3. TIME OF DEATH 9:30 P M	
4. SOCIAL SECURITY NUMBER 213-28-4858		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-12-1913	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Union Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Elkton	
9c. COUNTY OF DEATH Cecil County				10a. STATE Maryland		10b. COUNTY Cecil County	
10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 23 Maloney Road	
10f. ZIP CODE 21921				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Adolf A. Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Schisky			
19a. INFORMANT'S NAME (Type/Print) Ms. Loretta Mabe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Maloney Road, Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Good Shepherd Cemetery 12-29 Ellicott City, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Schalk</i> M00535				22. NAME AND ADDRESS OF FACILITY Slack Funeral Home Ellicott City, Maryland 21043			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SKIDIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Berte</i>				29c. LICENSE NUMBER 029901		29d. DATE SIGNED (Month, Day, Year) 12-26-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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ITEMS: 23 PART I, 27, 28a, b, c, d, e, f PER MEO G-695 1/8/93 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL D. MILES				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 2:31 A.M.			
4. SOCIAL SECURITY NUMBER 214-50-8348		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-31-48		8. BIRTHPLACE (State or Foreign Country) BALT.MD.	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MD.				10b. COUNTY A.A.CO.		10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8228 FT SMALLWOOD RD. APT 1C				10f. ZIP CODE 21226	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam - 1968-1970	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FORK LIFT OPERATOR				16b. KIND OF BUSINESS/INDUSTRY DISTRIBUTION SPECIALIST, INC.				17. FATHER'S NAME (First, Middle, Last) ALBERT EUGENE MILES	
18. MOTHER'S NAME (First, Middle, Maiden Surname) AUDREY WALLACE				19a. INFORMANT'S NAME (Type/Print) BARBARA HELTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8228 Ft. Smallwood Rd. Apt. 1C., Balto., MD 21226	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Crownsville Veterans Cem. 1/4/93 Crownsville, Md				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERALHOME P.A. 3111 Mountain Road Pasadena, Md. 21122				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BLUNT FORCE TRAUMA OF HEAD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year) 12/30/92				28b. TIME OF INJURY UNK. M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT STRUCK ON HEAD	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) CAPTAIN BUCK'S BAR				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) FT. SMALLWOOD RD				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12-30-1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. A. R. [Signature] MD 111 Penn Street, Baltimore, Maryland 21201				31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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2 10/10/79 10

10 10/10/79 10

92 37054

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORA MILLER		2. DATE OF DEATH MONTH DAY YEAR DEC. 28 1992		3. TIME OF DEATH 11:55 A M	
4. SOCIAL SECURITY NUMBER 577-60-3714		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.	
7. DATE OF BIRTH (Month, Day, Year) JULY 25, 1901		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) MILFORD MANOR NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? XX YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4001 CLARKS LANE, APT. 103		10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ADJUDICATOR		16b. KIND OF BUSINESS/INDUSTRY VETERANS ADMINISTRATION	
17. FATHER'S NAME (First, Middle, Last) ABRAHAM JOFFE		18. MOTHER'S NAME (First, Middle, Maiden Surname) RACHAEL BLUMBERG			
19a. INFORMANT'S NAME (Type/Print) MR BENJAMIN JOFFE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7025 CONCORD RD BALTO., MD 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW FRIENDSHIP 12-30-92		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cardiopulmonary Arrest		Approximate Interval Between Onset and Death Immediate	
		b. Myocardial Infarction		1 mo	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. Diabetes mellitus		10 yrs	
		d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SIP Smoke					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER P41584	
29d. DATE SIGNED (Month, Day, Year) JAN 4 1993		29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stuart Pollack MD			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37055

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Estelle T. Matthews				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92		3. TIME OF DEATH 7 PM	
4. SOCIAL SECURITY NUMBER 214 033627		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/20/08	
9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital 301 St. Paul				9b. CITY, TOWN OR LOCATION OF DEATH Balto, MD		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 719 S. POTOMAC ST.				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) WAITRESS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WAITRESS		16b. KIND OF BUSINESS/INDUSTRY RESTAURANT			
17. FATHER'S NAME (First, Middle, Last) JULIAN MALINOWSKI				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARYANNA ZULESKA			
19a. INFORMANT'S NAME (Type/Print) ANGELA M. MATTEWS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 FAIT AVE. BALTO. MD. 21224			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) ST-STANISLAUS CEM 1-2-93		20c. LOCATION — City or Town, State BALTO. CO. MD.		20d. DATE 1-2-93	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Skarda				22. NAME AND ADDRESS OF FACILITY SKARDA FH. 2829 HUDSON ST. 21224			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Pulmonary embolism DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Renal Failure							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas J. Lynch				29c. LICENSE NUMBER D42196		29d. DATE SIGNED (Month, Day, Year) 12/29/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas J. Lynch 301 St. Paul St. Suite 907 21202							
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE J. J. [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Willard Alvin Maraskey Jr.				2. DATE OF DEATH MONTH DAY YEAR 12 28 1992		3. TIME OF DEATH 9:10 A. M.					
4. SOCIAL SECURITY NUMBER 8632 213-68-8732		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04-12-1957		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) University Hoapital S.T.U.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City			9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER Steelton Avnue 1211		10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction		16b. KIND OF BUSINESS/INDUSTRY Dry Wall							
17. FATHER'S NAME (First, Middle, Last) Willard Alvin Maraskey Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Diana M. Beaulieu							
19a. INFORMANT'S NAME (Type/Print) Stella May Maraskey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steelton Avnue Balto., Md. 21224							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount		DATE 12/31		20c. LOCATION — City or Town, State Balto., Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Rajinski</i>				22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki P.A. F.H. 1005 Dundalk Ave. Balto., Md. 21224							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SHOTGUN WOUND TO ABDOMEN DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12/28/1992		28b. TIME OF INJURY 7:35A. M.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Self-Inflicted Gunshot Wound			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1211 Steelton Ave.							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark A. Rajinski</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/29/1992					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLIB, JR. MD 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									



1947-1948

92 37057

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WINIFRED MEDANIEL				2. DATE OF DEATH MONTH 12 DAY 26 YEAR 92		3. TIME OF DEATH 2:28 A M	
4. SOCIAL SECURITY NUMBER 577-10-3448		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/6/09	
8. BIRTHPLACE (State or Foreign Country) Wash, DC				9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE Maryland			
10b. COUNTY na				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER Harbor Inn Conval Center/LightStreet			
10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 12/30/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sephe Shock a. DUE TO (OR AS A CONSEQUENCE OF): s/p small bowel resection and hemicolectomy b. DUE TO (OR AS A CONSEQUENCE OF): ischemic Bowel disease c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 3
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart Failure Colitis for C. difficile							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J Caballero MD.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/26/92.	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YURI CABALLERO, Harbor Hospital Center, S. Hanover St. 3001 BALTIMORE, MD							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE Jane Sander-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37058

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry Nelson Nizer				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 5AM M	
4. SOCIAL SECURITY NUMBER 212-07-6621		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/12/07	
9a. FACILITY NAME (If not institution, give street and number) Meridian Cromwell Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5939 Falkirk Road				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Policeman		16b. KIND OF BUSINESS/INDUSTRY Baltimore City			
17. FATHER'S NAME (First, Middle, Last) Harry Rever Nizer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Genevieve Beier			
19a. INFORMANT'S NAME (Type/Print) Katherine Bauer Nizer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Dunkirk Road Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park		DATE 1/3/93		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Stephen Xenakis</i> Dennis Stephen Xenakis MD0640				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marion C. Kowalewski MD</i>			
29c. LICENSE NUMBER D21022				29d. DATE SIGNED (Month, Day, Year) 12-31-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marion Kowalewski 8604 Harford Road Baltimore, Maryland							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37059

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Madeline Anna NICOLAUS</i>				2. DATE OF DEATH MONTH DAY YEAR <i>12 23 92</i>		3. TIME OF DEATH <i>3:30 A M</i>	
4. SOCIAL SECURITY NUMBER <i>220-12-5933</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>01-30-1904</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Dorchester General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge, Maryland</i>		9c. COUNTY OF DEATH <i>Dorchester</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Dorchester</i>		10c. CITY, TOWN OR LOCATION <i>Taylor Island</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>Bayshore Road P.O. Box 25 4284</i>				10f. ZIP CODE <i>21669</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Manicurist</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Beauty Salon</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Martin Sellman</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Regina Muller</i>			
19a. INFORMANT'S NAME (Type/Print) <i>George Baiert</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Bayshore Road Box 25 Taylors Island 21669</i>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Sacred Heart of Jesus</i>		20c. LOCATION — City or Town, State <i>12/26 Dundalk, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Rymaszewski</i>				22. NAME AND ADDRESS OF FACILITY <i>W. Dabrowski/Chojnacki P.A. F. H. 1005 Dundalk Ave. Balto., Md. 21224</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <i>Pulmonary infection</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemia, CHF, Organic B Syndrome</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Tanman</i>				29c. LICENSE NUMBER <i>214349</i>		29d. DATE SIGNED (Month, Day, Year) <i>12-23-92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Tanman Dorchester General Hospital Cambridge, MD 21613</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 4 1993</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37060

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARJORIE JANE PRENTICE			2. DATE OF DEATH MONTH 12 DAY 11 YEAR 92			3. TIME OF DEATH 3:54 M		
4. SOCIAL SECURITY NUMBER 375-12-3465			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F			6. AGE (In yrs. last birthday) 72 YRS.		
7. DATE OF BIRTH (Month, Day, Year) 8-19-20			8. BIRTHPLACE (State or Foreign Country) Michigan			9. COUNTY OF DEATH na		
9a. FACILITY NAME (If not institution, give street and number) Joseph Richey Hospice 828 N. EUTAW ST. BALTIMORE MD								
10a. STATE MD			10b. COUNTY na			10c. CITY, TOWN OR LOCATION 104 Glenrae Drive Baltimore		
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			10e. STREET AND NUMBER 104 Glenrae Drive			10f. ZIP CODE 21228		
10g. CITIZEN OF WHAT COUNTRY? USA			11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY Homemaker			17. FATHER'S NAME (First, Middle, Last) Fred Raymond Endsley		
18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Mae Mead			19a. INFORMANT'S NAME (Type/Print) Linda Prentice			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Glenrae Drive, Catonsville, MD 21228		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir			22. NAME AND ADDRESS OF FACILITY State Anatomy Board			23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		
24. DATE OF DEATH 12/30/92			25. NAME AND ADDRESS OF FACILITY 655W. Baltimore Street, Balto, MD 21201			26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
27. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest			28. DUE TO (OR AS A CONSEQUENCE OF): Carcinomatosis Peritoneum			29. DUE TO (OR AS A CONSEQUENCE OF): Adenocarcinoma of Ovary		
30. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			31. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			32. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
33. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			34. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice			35. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		
36. DATE OF INJURY (Month, Day, Year)			37. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N			38. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			40. DESCRIBE HOW INJURY OCCURRED			41. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
42. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			43. SIGNATURE AND TITLE OF CERTIFIER Robert C. Irwin MD			44. LICENSE NUMBER D08900		
45. DATE SIGNED (Month, Day, Year) 12-11-92			46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert C. Irwin MD 828 N. Eutaw St. Balto. Md 21201			47. DATE FILED (Month, Day, Year) JAN 4 1993		
48. REGISTRAR'S SIGNATURE John Benjamin Rutherford			49. DATE OF DEATH 12-30-92			50. TIME OF DEATH 3:54		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

to be the first of a new
series of events which
will be of great importance

and the first of a new
series of events which
will be of great importance
The first of a new
series of events which
will be of great importance

92 37061

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER P. PIDGEON				2. DATE OF DEATH MONTH 12 DAY 24 YEAR 92		3. TIME OF DEATH 9:55 A.M.	
4. SOCIAL SECURITY NUMBER 182-05-7253		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		5. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-22-05	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN MULTIMEDICAL				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION JARRETTSVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4041 HUNT CREST ROAD				10f. ZIP CODE 21084		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Advertising Executive		16b. KIND OF BUSINESS/INDUSTRY Newspaper			
17. FATHER'S NAME (First, Middle, Last) James H. Pidgeon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Sheehan			
19a. INFORMANT'S NAME (Type/Print) Mrs. Patricia Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 West Wayne Ave. Easton, Pennsylvania 18045			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery		20c. LOCATION — City or Town, State Yeadon, Pennsylvania			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael P. Marzullo				22. NAME AND ADDRESS OF FACILITY Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. Decubiti DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multi-infarct Dementia GI Bleeding						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Alan Shroffsky				29c. LICENSE NUMBER D24569		29d. DATE SIGNED (Month, Day, Year) 12/24/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 660 Kenilworth Dr Towson, MD 21204							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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12057 82

12057 82

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN				2. DATE OF DEATH MONTH DAY YEAR 12 26 92				3. TIME OF DEATH 7:43 P M			
4. SOCIAL SECURITY NUMBER 217-07-6928		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-7-06		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) 1805 E. PRATT STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH			
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1805 E. PRATT ST.				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONG SHOREMEN		16b. KIND OF BUSINESS/INDUSTRY STEAMSHIP TRADE							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
19a. INFORMANT'S NAME (Type/Print) MR MELVIN RUSZKIEWICZ				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 FLEET ST. BALTO MD 21224							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT		DATE 1-4-92		20c. LOCATION — City or Town, State BALTO City, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Raymond H. Hazzard				22. NAME AND ADDRESS OF FACILITY							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INQUIRY		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER J. L. Locke MD				29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) 12/27/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. L. Locke MD 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37063

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Warren E. Pearman				2. DATE OF DEATH MONTH DAY YEAR Dec. 31, 1992		3. TIME OF DEATH 1:45 p.m.	
4. SOCIAL SECURITY NUMBER 218-28-9836		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/14/34	
8a. FACILITY NAME (If not institution, give street and number) 3505 Clover Avenue				8b. CITY, TOWN OR LOCATION OF DEATH Lansdowne		8c. COUNTY OF DEATH Baltimore	
9. RESIDENCE OF DECEDENT				10a. STATE Md		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Lansdowne				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. CITIZEN OF WHAT COUNTRY? usa	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) machinist		16b. KIND OF BUSINESS/INDUSTRY factory			
17. FATHER'S NAME (First, Middle, Last) Warren E. Pearman, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frieda Keuler			
19a. INFORMANT'S NAME (Type/Print) Norma J. Pearman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 Clover Avenue Lansdowne Md 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. LOCATION — City or Town, State Baltimore, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home 1328 Sulphur Spring Road, Arbutus, Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Lung ca & brain metastasis b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Gloria R. [Signature] M.D.				29c. LICENSE NUMBER D39834		29d. DATE SIGNED (Month, Day, Year) 1/2/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7375-025

blh

ITEMS: 23 PART I, 27 PER MEO G-695 1/12/93 reb

92 37064

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kevin Joseph PRIESTLEY				2. DATE OF DEATH MONTH DAY YEAR 12 24 1992		3. TIME OF DEATH 9:50 PM	
4. SOCIAL SECURITY NUMBER 230-68-2845		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/27/1956	
8. BIRTHPLACE (State or Foreign Country) VERMONT				9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fallston	
9c. COUNTY OF DEATH Harford				10a. STATE MAINE		10b. CITY, TOWN OR LOCATION WASHINGTON	
10c. CITY, TOWN OR LOCATION EAST MACHIAS				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER Route 1 P.O. Box 347	
10f. ZIP CODE 04630				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSISTANT MANAGER		16b. KIND OF BUSINESS/INDUSTRY LOBSTER POUND	
17. FATHER'S NAME (First, Middle, Last) JOSEPH R. PRIESTLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA SNYDER			
19a. INFORMANT'S NAME (Type/Print) MARCIA L. PRIESTLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 347 EAST MACHIAS, ME 04630			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HIGHLAND CEMETERY 12/28		20c. LOCATION — City or Town, State STREET, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey P. Lovelidge				22. NAME AND ADDRESS OF FACILITY HARKINS FUNERAL HOME, INC. DELTA, PA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12 25 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) [Signature] 1111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 4 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37065

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ADELINE REED (ADLINE REED)				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 0450 M	
4. SOCIAL SECURITY NUMBER 220-24-1988		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-11-1900	
8. BIRTHPLACE (State or Foreign Country) West VA				9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH				10a. STATE MD			
10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1112 Bonaparte Ave.			
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) Housewife				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			
16b. KIND OF BUSINESS/INDUSTRY				17. FATHER'S NAME (First, Middle, Last) Richard			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane				19a. INFORMANT'S NAME (Type/Print) Annie Stockett			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 Bonaparte Ave./Baltimore, MD 21218				20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park				20c. LOCATION — City or Town, State Randallstown, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH F.H./1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIORESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. COPD, CHF, RECENT PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Infiltrating CA breast							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Megastalon INTERNAL MED RESIDENT				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. P. APOSTOLOU 90 UNION MEMORIAL HOSP 201 E. UNIVERSITY PKWY BALTIMORE, MD 21218							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

1. FOR
STATE
REGISTRAR

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) HUGH MASON RICE				2. DATE OF DEATH MONTH DAY YEAR 12 31 92		3. TIME OF DEATH 12:40 p M	
4. SOCIAL SECURITY NUMBER 218-01-9792		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-13-16	
9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL X CORPORATION				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH VA	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 235 E. LAFAYETTE AVE.				10f. ZIP CODE 21202		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Roofing			
17. FATHER'S NAME (First, Middle, Last) JIMMIE LEE RICE				18. MOTHER'S NAME (First, Middle, Maiden Surname) HINDA JAMES			
19a. INFORMANT'S NAME (Type/Print) LEON SAVOY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 JAMESTOWN CT./EDGEWOOD, MD 21040					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA. CEM.		DATE		20c. LOCATION — City or Town, State OWINGS MILLS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Chronic renal failure, CHF DUE TO (OR AS A CONSEQUENCE OF): c. Hypertensive nephrosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Hypertension							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year) 12-31-92		28b. TIME OF INJURY 1240p M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Hospital				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Church Hospital			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Noreen Rahat Hashmi</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12-31-92 11:40p	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NOREEN RAHAT HASHMI CHURCH HOME HOSPITAL							
31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

92 37067

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kathryn Reaves				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 4:45 p.m.		
4. SOCIAL SECURITY NUMBER 249-52-8758		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-3-31		
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH		
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 1505 BRADDOCK AVE				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? U.S.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cabotera Supervisor		16b. KIND OF BUSINESS/INDUSTRY School for the blind				
17. FATHER'S NAME (First, Middle, Last) ALTON JONES				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELEANOR SIDNER				
19a. INFORMANT'S NAME (Type/Print) Rev. Andrew Reaves				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Braddock Ave Balto. MD 21216				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calverton Bkfst 1-5		20c. LOCATION — City or Town, State Dwight Mills Md				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Mott				22. NAME AND ADDRESS OF FACILITY James A. Mott & Sons Funeral Home 1701 Calverton St				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous cell lung cancer DUE TO (OR AS A CONSEQUENCE OF):								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. respiratory failure DUE TO (OR AS A CONSEQUENCE OF):								
c. _____ DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER RESIDENT PHYSICIAN ST. AGNES				29c. LICENSE NUMBER ST. AGNES		29d. DATE SIGNED (Month, Day, Year) 12/30/92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. CHARLES ALAKIA ST. AGNES HOSP., CATONSVILLE MD 21229								
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE [Signature]				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37068

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT S. ROTH				2. DATE OF DEATH MONTH 12 DAY 27 YEAR 92		3. TIME OF DEATH 10:40 P M	
4. SOCIAL SECURITY NUMBER 217 26 1755		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/11/1899	
8. BIRTHPLACE (State or Foreign Country) NEW YORK				9. FACILITY NAME (If not institution, give street and number) VA MEDICAL CENTER FORT HOWARD			
10. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD				11. COUNTY OF DEATH BALTIMORE			
12a. STATE MARYLAND		12b. COUNTY na		12c. CITY, TOWN OR LOCATION BALTIMORE		12d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13. STREET AND NUMBER 5616 SEWARD AVENUE				14. ZIP CODE 21206		15. CITIZEN OF WHAT COUNTRY? USA	
16. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: WHITE	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SHEET METAL WORKER		22. KIND OF BUSINESS/INDUSTRY			
23. FATHER'S NAME (First, Middle, Last) SAMUEL ROTH				24. MOTHER'S NAME (First, Middle, Maiden Surname) SYLVIA MARGARET PAVLO			
25. INFORMANT'S NAME (Type/Print) Doris Williams				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLINICAL RECORDS 1316 Sweet Briar Ln, BELAIR, MD 21052			
27. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE _____		29. LOCATION — City or Town, State			
30. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 12/30/92				31. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ORGANIC BRAIN SYNDROME WITH DEMENTIA							
34. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		35. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		36. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		37. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
38. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		39. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		40. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		41. DESCRIBE NOW INJURY OCCURRED	
42. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		43. SIGNATURE AND TITLE OF CERTIFIER [Signature]		44. LICENSE NUMBER D30528		45. DATE SIGNED (Month, Day, Year) 12/27/92	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. BALA DUGGIRALA, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052							
47. DATE FILED (Month, Day, Year) JAN 4 1993		48. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37069

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Small Jr.						2. DATE OF DEATH MONTH DAY YEAR December 24, 1992		3. TIME OF DEATH 10:52 A.	
4. SOCIAL SECURITY NUMBER 213 26 0615		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-22-32		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) Loch Raven VA Medical Center						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 512 STREEPER STREET				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) UNEMPLOYED				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) JOHN SMALL, SR.						18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLET DAVIS			
19a. INFORMANT'S NAME (Type/Print) FANNIE MCCREADY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 BOWLEYS LANE APT. 4-A/BALTIMORE, MD 21206					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA. CEM.		20c. LOCATION — City or Town, State OWINGS MILLS, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cirrhosis/ DUE TO (OR AS A CONSEQUENCE OF): b. Ethanol Abuse DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2-5 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coagulopathy, renal insufficiency, chronic pancreatitis, IVD, Hep B HAc (+), Ascites								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.						29c. LICENSE NUMBER MR0596		29d. DATE SIGNED (Month, Day, Year) 12/24/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22 S. Greene Street (Dept. of Internal Medicine)									
31. DATE FILED (Month, Day, Year) JAN 4/94 1993				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37070

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) IRVIN SILVERMAN				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1992				3. TIME OF DEATH 7:25A M	
4. SOCIAL SECURITY NUMBER 212-18-8294		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 25, 1916		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD	
9a. FACILITY NAME (If not institution, give street and number) SUMMIT NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEASED									
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5932 CHARLES STREET				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th GRADE College (1-4 or 5+) College				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ENTREPRENEUR		16b. KIND OF BUSINESS/INDUSTRY PRODUCE			
17. FATHER'S NAME (First, Middle, Last) JULIUS SILVERMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE FREEDMAN					
19a. INFORMANT'S NAME (Type/Print) ESTHER MALVINA SILVERMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5932 CHARLES STREET - BALTIMORE, MD. 21207					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 01/02/		20c. LOCATION — City or Town, State BALTIMORE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dawn E. Fisher</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 21229 4107 WILKENS AVENUE-BALTIMORE, MARYLAND					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration Pneumonia</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Aspiration Pneumonia Disease</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Demerol BPH dehydration</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alejandro Mejia</i>				29c. LICENSE NUMBER D08780		29d. DATE SIGNED (Month, Day, Year) 12-30-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ALEJANDRO MEJIA - 405 FREDERICK ROAD - SUITE 151 - BALTIMORE, MD. 21228									
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

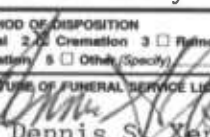

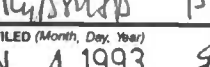
1 - FOR
STATE
REGISTRAR

DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL E. SEELY				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 8:10 A.M.			
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-18-57		8. BIRTHPLACE (State or Foreign Country) North Carolina	
9a. FACILITY NAME (If not institution, give street and number) 2022 N. CALVERT STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore City	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1209 Winston Avenue				10f. ZIP CODE 21239	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Musician				16b. KIND OF BUSINESS/INDUSTRY Self-employed	
17. FATHER'S NAME (First, Middle, Last) Nathan Thomas Seely, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Meloria Sargeant					
19a. INFORMANT'S NAME (Type/Print) Dr. Julia L. Seely				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Winston Avenue, Baltimore, Maryland 21239					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery 01/02/93				20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Dennis S. Xenakis				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEIZURE DISORDER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NARCOTIC AND COCAINE ABUSE								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 2022 N. CALVERT ST.				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER  P. Koron	
29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) 12-31-1992					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. Koron 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE  Julia Davidson					

92 37072

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Betsy P. Snyder				2. DATE OF DEATH MONTH 12 DAY 23 YEAR 92		3. TIME OF DEATH 6:50 P M	
4. SOCIAL SECURITY NUMBER 212-09-2772		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/30/11	
8. BIRTHPLACE (State or Foreign Country) Canada				9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH Md.				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER Guilford Towers 14 W. Cold Spring La	
10f. ZIP CODE 21210				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Secretary		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Richard B. Snyder				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian W. Harris			
19a. INFORMANT'S NAME (Type/Print) Mrs. Nancy W. Murray				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Terrace Glen Baltimore, MD. 21210			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE C. Sherman Denny, Jr.				22. NAME AND ADDRESS OF FACILITY MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mayer Gorbatsky M.D.				29c. LICENSE NUMBER D27938		29d. DATE SIGNED (Month, Day, Year) 12/23/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mayer Gorbatsky, M.D. 785 Aqueduct Rd. Glen Burnie, MD							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SALLIE SMITH				2. DATE OF DEATH MONTH 12 DAY 26 YEAR 92		3. TIME OF DEATH 12:52pm	
4. SOCIAL SECURITY NUMBER 213-34-2155		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/28/31	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MD				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1128 Wilmount Court			
10f. ZIP CODE 21205				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Food Service Worker		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Henry Taylor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bethel McRae			
19a. INFORMANT'S NAME (Type/Print) Bethel Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 S. Hilton St., Baltimore, MD			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star		DATE 12/31		20c. LOCATION — City or Town, State Baltimore	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eugene R. Price</i>				22. NAME AND ADDRESS OF FACILITY Eugene R. Price Funeral Home 108 W. North Ave., Balto., MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Electromechanical dissociation DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 5 minutes	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Possible PE Pulmonary embolism DUE TO (OR AS A CONSEQUENCE OF):				20 minutes	
		c. Possible Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF):				2 hours	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. E.T.H. Abuse, HTN 7th Grade Pals vs stroke Possible W. Pyloric A. C.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/26/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Powell J. H. H.							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37074

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH V. SAH				2. DATE OF DEATH MONTH 12 DAY 26 YEAR 92		3. TIME OF DEATH 6 13 P M	
4. SOCIAL SECURITY NUMBER 213-06-2700		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 22 YRS.	7. DATE OF BIRTH (Month, Day, Year) 02 24 70	8. BIRTHPLACE (State or Foreign Country) Bethesda, MD		
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE VA				10b. COUNTY Fairfax		10c. CITY, TOWN OR LOCATION HERNDON	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 3230 TRANQUILITY LANE			
10f. ZIP CODE 22071				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Paint Specialist		15b. KIND OF BUSINESS/INDUSTRY Paint Store			
17. FATHER'S NAME (First, Middle, Last) Yousef I. Saah				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nelly L. Deeb			
19a. INFORMANT'S NAME (Type/Print) Yousef I. Saah				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3230 Tranquility Ln, Herndon, VA 22071			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) National Memorial Park 12/30 Falls Church, VA		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel N. Deeb</i>				22. NAME AND ADDRESS OF FACILITY Murphy Falls Church Funeral Home, 1102 W. Broad St, Falls Church, VA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 3 DAYS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)		27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12 23 92		28b. TIME OF INJURY 1730 M	
28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED MVA MOTOR CYCLE		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) CHAPMAN AVE METRO	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francis C. Mayo</i>				29c. LICENSE NUMBER 007099		29d. DATE SIGNED (Month, Day, Year) 12/27/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) FRANCIS C. MAYO 10015 Fernwood Rd Bethesda MD 20817							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>Francis C. Mayo</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Dorothy M. Sheckels</u>				2. DATE OF DEATH MONTH <u>12</u> DAY <u>29</u> YEAR <u>92</u>				3. TIME OF DEATH <u>11:35 a.m.</u>							
4. SOCIAL SECURITY NUMBER <u>217-225730</u>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>78</u> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____ HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) <u>5-13-14</u>		8. BIRTHPLACE (State or Foreign Country) <u>Md.</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>St. Agnes Hospital</u>						9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>				9c. COUNTY OF DEATH <u>N/A</u>					
RESIDENCE OF DECEDENT															
10a. STATE <u>Md.</u>				10b. COUNTY <u>N/A</u>				10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <u>812 Stamford Rd. - Baltimore, Md.</u>						10f. ZIP CODE <u>21229</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>N/A</u>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>N/A</u> College (14 or 5+) <u>N/A</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Secretary</u>				16b. KIND OF BUSINESS/INDUSTRY <u>John Hancock</u>							
17. FATHER'S NAME (First, Middle, Last) <u>Harry P. Blanquette</u>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Katherine V. Rice</u>									
19a. INFORMANT'S NAME (Type/Print) <u>Joan M. Compher</u>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>10 Pomona South - Apt. #9 - Pikesville, Md. 21208</u>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Meadowridge Cemetery 12-31-92</u>				20c. LOCATION — City or Town, State <u>Howard Co., Md.</u>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>G. Truman Schwab</u>						22. NAME AND ADDRESS OF FACILITY <u>5151 Baltimore National Pike Baltimore, Md. 21229</u>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiac Arrest</u>												<u>2 days</u>			
a. DUE TO (OR AS A CONSEQUENCE OF):															
b. DUE TO (OR AS A CONSEQUENCE OF): <u>Chronic Obstructive Pulmonary Disease</u>												<u>10 years</u>			
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Proximal Encephalopathy post recurrent stroke</u>															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Jeffrey F. Cole, MD</u>						29c. LICENSE NUMBER <u>M21512</u>				29d. DATE SIGNED (Month, Day, Year) <u>12/29/92</u>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Jeffrey F. Cole, MD 3455 Wilkens Avenue 21229</u>															
31. DATE FILED (Month, Day, Year) <u>JAN 4 1993</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37076

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WARREN SPARROW				2. DATE OF DEATH MONTH 12 DAY 24 YEAR 92		3. TIME OF DEATH 12:23 P M	
4. SOCIAL SECURITY NUMBER 216-78-0881		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-10-59	
9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL CORPORATION				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH na	
10a. STATE N. Carolina				10b. COUNTY		10c. CITY, TOWN OR LOCATION Elizabeth City	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER			
10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir <i>Ronald Wade</i> 12/30/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Failure Syndrome Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): Pneumocystis Pneumonia c. DUE TO (OR AS A CONSEQUENCE OF): AIDS d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Bokhari</i> M.D.				29c. LICENSE NUMBER D 26594		29d. DATE SIGNED (Month, Day, Year) 12/24/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHURCH HOSPITAL CORPORATION DR. RIAZ BOKHARI, M.D. 100 N. BROADWAY BALTIMORE, MARYLAND 21231							
31. DATE FILED (Month, Day, Year) JAN 4 1993				32. REGISTRAR'S SIGNATURE <i>John Benner-Rubel</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 4 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 4 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				92 37077			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) GEORGINIA roberta THURSBY				2. DATE OF DEATH MONTH DAY YEAR 12 29 92				3. TIME OF DEATH 07:20 AM M			
4. SOCIAL SECURITY NUMBER 220-44-7437		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 101 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/13/1891		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				9c. COUNTY OF DEATH A.A. COUNTY			
10a. STATE Maryland		10b. COUNTY A.A.		10c. CITY, TOWN OR LOCATION Pasadena		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 677 Cedar Drive		10f. ZIP CODE 21122	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		17. FATHER'S NAME (First, Middle, Last) George Littleton Seward		18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily J. Muckleroy		19a. INFORMANT'S NAME (Type/Print) John Edward Thursby III		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 677 Cedar Drive Pasadena Maryland 21122	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) David Ridge 12/31		20c. LOCATION — City or Town, State Pikesville, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis M00640		22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Right Pleural Effusion DUE TO (OR AS A CONSEQUENCE OF): c. Right Pneumonia DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death 12 hrs 10/92 10/92							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Old Age				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Harold G. Hebard MD		29c. LICENSE NUMBER D31244		29d. DATE SIGNED (Month, Day, Year) 12-29-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAROLD G. HEBARD, M.D. / 4710 PENNINGTON AVENUE / BALTIMORE, MARYLAND 21226				31. DATE FILED (Month, Day, Year) JAN 4 1993		32. REGISTRAR'S SIGNATURE John Edward Thursby III					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		92 37078	
CERTIFICATE OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <i>REGINA S. WILLIAMS</i>		2. DATE OF DEATH MONTH <i>12</i> DAY <i>23</i> YEAR <i>92</i>		3. TIME OF DEATH <i>10:31 A</i>	
4. SOCIAL SECURITY NUMBER <i>579 72 2999</i>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>35</i> YRS.	7. DATE OF BIRTH MONTH <i>9</i> DAY <i>19</i> YEAR <i>1957</i>	8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) <i>SO MARYLAND HOSP</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>CLINTON</i>		9c. COUNTY OF DEATH <i>PRINCE GEORGE</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince Geo co</i>		10c. CITY, TOWN OR LOCATION <i>Clinton</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>9211 Stuart Lane</i>		10f. ZIP CODE <i>20735</i>	
10g. CITIZEN OF WHAT COUNTRY?		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Gladys Dixon</i>	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		20. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>in state removal</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> <i>12/30/92</i>		22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board</i> <i>655W. Baltimore St, Balto, MD 21201</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac arrest</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>HIV Positive</i> <i>Septicemia</i> <i>fungal infect</i>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>K. Daniel MD</i>		29c. LICENSE NUMBER <i>D25640</i>	
29d. DATE SIGNED (Month, Day, Year) <i>12-24-92</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rhosnow Davachi 1328 So. Ave Wash-DC 20032</i>		31. DATE FILED (Month, Day, Year) <i>JAN 4 1993</i>	
32. REGISTRAR'S SIGNATURE <i>John Sanderford</i>					

92 37079

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Arthur Allen</i> ARTHUR JOHN ALLEN				2. DATE OF DEATH MONTH DAY YEAR 12 - 19 92		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216-07-9464A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-09-1893	
8. BIRTHPLACE (State or Foreign Country) MD.				9a. FACILITY NAME (If not institution, give street and number) 6319 Jones Village		9b. CITY, TOWN OR LOCATION OF DEATH HURLOCK	
9c. COUNTY OF DEATH DORCHESTER				10a. STATE MD.		10b. COUNTY DORCHESTER	
10c. CITY, TOWN OR LOCATION HURLOCK				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 6319-Jones Village	
10f. ZIP CODE 21643				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) John Allen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Stewart			
19a. INFORMANT'S NAME (Type/Print) DeLores Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6319 Jones Village Hurlock, MD. 21643			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Pleasant Cemetery		20c. LOCATION — City or Town, State Salem, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janelle C. Henry</i>				22. NAME AND ADDRESS OF FACILITY HENRY FUNERAL HOME 510 Washington St. Cambridge, MD. 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CHF</i>							
DUE TO (OR AS A CONSEQUENCE OF): <i>Crown Heart disease</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Dehydrated state (Chronic)</i> }							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. Davidson-Randall</i>				29c. LICENSE NUMBER D26388		29d. DATE SIGNED (Month, Day, Year) 12/21/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) DEC 21 '92				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This is to certify that the death certificate was executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST-100

ST-100

92 37080

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hazel Okra Ayers				2. DATE OF DEATH MONTH DAY YEAR 12 23 1992		3. TIME OF DEATH 7:20 p M	
4. SOCIAL SECURITY NUMBER 220-16-0597		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-3-1913	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9. COUNTY OF DEATH Carroll			
10. FACILITY NAME (If not institution, give street and number) Long View Nursing Home				11. CITY, TOWN OR LOCATION OF DEATH Manchester			
12. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Carroll			
10c. CITY, TOWN OR LOCATION Hampstead				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1632 North Main Street				10f. ZIP CODE 21074		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clothing		16b. KIND OF BUSINESS/INDUSTRY Sewing Factory			
17. FATHER'S NAME (First, Middle, Last) Charles Cannon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Darcus Cannon			
19a. INFORMANT'S NAME (Type/Print) Dorothy Fuller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3932 Sunset Dr, Hampstead, MD. 21074			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Lutheran Cem. 12-27-1992		20c. LOCATION — City or Town, State Manchester, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. Garth Eckhardt				22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, MD. 21102			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): Intermittent Heart Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Vascular Accident Rheumatoid Arthritis							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W H F Oard MD				29c. LICENSE NUMBER D02386		29d. DATE SIGNED (Month, Day, Year) 12/23/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W H F Oard MD, 3223 MAIN ST, MANCHESTER, MD 21102							
31. DATE FILED (Month, Day, Year) DEC 24 '92		32. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37081

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HATTIE F. ABBOTT				2. DATE OF DEATH MONTH 12 DAY 17 YEAR 92		3. TIME OF DEATH 6:30 A. M	
4. SOCIAL SECURITY NUMBER 218-01-2497		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-30-14	
9a. FACILITY NAME (If not institution, give street and number) 454 Charlotte Ave. (Home)				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset	
10a. STATE MD				10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 454 Charlotte Ave.				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 7 College (13-16 or 17+) --		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Cap Factory			
17. FATHER'S NAME (First, Middle, Last) James Henry Sterling				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kate Burke			
19a. INFORMANT'S NAME (Type/Print) Victoria Huffman (daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4605 Jacksonville Road - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park		20c. LOCATION — City or Town, State Crisfield, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Burdett				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cor Pulmonale Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Chronic Obstructive Pulmonary Disease a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death Years Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Duodenal ulcers							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James A. Sterling, MD				29c. LICENSE NUMBER D 10214		29d. DATE SIGNED (Month, Day, Year) 12/18/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Sterling, MD -- 320 W. Main Sy. -- Crisfield, MD 21817							
31. DATE FILED (Month, Day, Year) DEC 22 '92				32. REGISTRAR'S SIGNATURE Julia Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37082

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Donald Maynard Adams						2. DATE OF DEATH MONTH DAY YEAR 12-20-92		3. TIME OF DEATH 1:47 a.m.	
4. SOCIAL SECURITY NUMBER 220-28-1769		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 18, 1933		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 231 Somers Cove Apts.				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean War		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Grade 10 - - -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman		16b. KIND OF BUSINESS/INDUSTRY Seafood			
17. FATHER'S NAME (First, Middle, Last) Alton Maynard Adams						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruby Mears			
19a. INFORMANT'S NAME (Type/Print) Shirley A. Adams (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 a,b,c,d,e,f,g					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park-12/22/92		DATE 12-22-92		20c. LOCATION — City or Town, State Crisfield, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons, Main St., Crisfield, Md. (21817)					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction									
DUE TO (OR AS A CONSEQUENCE OF):									
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Albert Dacanay						29c. LICENSE NUMBER D 29987		29d. DATE SIGNED (Month, Day, Year) 12-20-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Albert Dacanay, 309 Timmons St., Snow Hill, Md. 21863									
31. DATE FILED (Month, Day, Year) DEC 22 '92				32. REGISTRAR'S SIGNATURE Julia Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92-37083

1. DECEDENT'S NAME (First, Middle, Last) William C. Bowling				2. DATE OF DEATH MONTH 12 DAY 21 YEAR 1992		3. TIME OF DEATH 3:00 pm	
4. SOCIAL SECURITY NUMBER 229-07-1687		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs., last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08/12/09	
8. BIRTHPLACE (State or Foreign Country) Georgia		9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fallston, Maryland		9c. COUNTY OF DEATH Harford	
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Pylesville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1935 Telegraph Road				10f. ZIP CODE 21132		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) missionary		17. KIND OF BUSINESS/INDUSTRY church			
17. FATHER'S NAME (First, Middle, Last) Aisbeary Bowling				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel			
19a. INFORMANT'S NAME (Type/Print) Mrs. Cora Bowling				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1935 Telegraph Road, Pylesville, MD 21132			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Mem. Gardens 12/23 Finksburg, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert K. Pritts, Sr.				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Severe IHD. ABLU						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung to me.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER U.S. NARMD				29c. LICENSE NUMBER D16444		29d. DATE SIGNED (Month, Day, Year) DEC 23 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2112 Pulaski Road, Pikesville, MD 21047							
31. DATE FILED (Month, Day, Year) DEC 23 1992				32. REGISTRAR'S SIGNATURE Julian B. ...			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		92 37084	
1 -		CERTIFICATE OF DEATH		REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Evelyn Frances Black		2. DATE OF DEATH MONTH DAY YEAR 12-19-1992		3. TIME OF DEATH 5:45Am M	
4. SOCIAL SECURITY NUMBER 217-36-1828		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.	
7. DATE OF BIRTH MONTH DAY YEAR 05-16-39		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's Co Hospital INC.		9b. CITY, TOWN OR LOCATION OF DEATH Chestertown		9c. COUNTY OF DEATH Kent	
RESIDENCE OF DECEDENT					
10a. STATE MD.		10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Chestertown	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 205 ROOSEVELT DR.		10f. ZIP CODE 21620	
10g. CITIZEN OF WHAT COUNTRY? U.S.A		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) Secondary		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABOR		16b. KIND OF BUSINESS/INDUSTRY VARIOUS	
17. FATHER'S NAME (First, Middle, Last) ARTHUR BOND		18. MOTHER'S NAME (First, Middle, Maiden Surname) ENNA DICKERSON			
19a. INFORMANT'S NAME (Type/Print) MRS. SHARON MCCINTON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 ROOSEVELT DR. CHESTERTOWN, MD 21620			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) JAMES CEM. 12/24/92		20c. LOCATION — City or Town, State CHESTERTOWN	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]		22. NAME AND ADDRESS OF FACILITY 207 RIVERSIDE ST. CHESTERTOWN, MD. 21620			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute decompensation of chronic respiratory failure DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. brainstem herniation DUE TO (OR AS A CONSEQUENCE OF):					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease cor pulmonale					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER M. Bienenfeld M.D.		29c. LICENSE NUMBER D 33514		29d. DATE SIGNED (Month, Day, Year) 12-19-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL BIENFELD CHESTERTOWN, MD. 21620					
31. DATE FILED (Month, Day, Year) 4 DEC 22 '92		32. REGISTRAR'S SIGNATURE John Davidson-Randall			

For the purpose of the present investigation, the following
data were obtained from the various sources mentioned above.
The results are given in the following table, which shows
the relative amounts of the various components of the
mixture, as determined by the various methods mentioned
above. The results are given in the following table, which
shows the relative amounts of the various components of the
mixture, as determined by the various methods mentioned
above.

It is seen from the above that the results obtained by the
various methods are in good agreement, and that the
mixture is composed of the following components:

1. The first component is the most abundant, and is
the most stable, and is the most characteristic of the
mixture.

2. The second component is the second most abundant,
and is the second most stable, and is the second most
characteristic of the mixture.

3. The third component is the third most abundant,
and is the third most stable, and is the third most
characteristic of the mixture.

92 37085

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>LINDY R. Bromley</u>				2. DATE OF DEATH MONTH <u>DECEMBER</u> DAY <u>12</u> YEAR <u>1992</u>		3. TIME OF DEATH <u>2215</u> M	
4. SOCIAL SECURITY NUMBER <u>213-22-5000</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>65</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>05 24 1927</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not Institution, give street and number) <u>PENINSULA REGIONAL MEDICAL CENTER</u>			
9b. CITY, TOWN OR LOCATION OF DEATH <u>SALISBURY</u>				9c. COUNTY OF DEATH <u>WICOMICO</u>			
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Somerset</u>		10c. CITY, TOWN OR LOCATION <u>Princess Anne</u>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <u>12208 Somerset Avenue</u>			
10f. ZIP CODE <u>21853</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>U.S.</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College (1-4 or 5 +)</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Chip Mill Foreman</u>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <u>Clayton W. Bromley</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Myrtle Beauchamp</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Mary M. Bromley</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>12208 Somerset Ave., Pr. Anne, Md. 21853</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Beechwood Cemetery 12/15</u>		20c. LOCATION — City or Town, State <u>Pr. Anne, Maryland</u>		20d. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James J. Krissman</u> MO0295				22. NAME AND ADDRESS OF FACILITY <u>Hinman Funeral Home, Pr. Anne, Md</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory Failure</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <u>Sen. Arteriosclerotic Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Due to (OR AS A CONSEQUENCE OF):</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Arteriosclerotic Heart Disease</u> <u>Coronary Arteriosclerotic Heart Disease</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>John S. Sue</u>				29c. LICENSE NUMBER <u>00020</u>		29d. DATE SIGNED (Month, Day, Year) <u>12/13/92</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John Gary Grace</u> <u>Princess Anne Hwy 50/161/10</u>							
31. DATE FILED (Month, Day, Year) <u>DEC 14 '92</u>		32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37086

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nadine Deere BUSSEY				2. DATE OF DEATH MONTH DAY YEAR Dec. 11, 1992		3. TIME OF DEATH 11:00 a.m.	
4. SOCIAL SECURITY NUMBER 214-74-3516		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 20, 1910	8. BIRTHPLACE (State or Foreign Country) Texas		
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 900 Preston Street				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Edgar R. Deere				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Dargitz			
19a. INFORMANT'S NAME (Type/Print) Stanley Bussey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8500 NW 92nd Street Oklahoma City, OK 73132			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oakland Cemetery		20c. DATE 12/15		20d. LOCATION — City or Town, State Oakland Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Franklin H. Custer</i>				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 South Second Street Oakladd, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart + Failure</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Supraventricular tachycardia</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Jerry Adams</i>				29c. LICENSE NUMBER D39811		29d. DATE SIGNED (Month, Day, Year) 12/14/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Jerry Adams 311 N. Fourth St., Oakland, Maryland 21550							
31. DATE FILED (Month, Day, Year) DEC 15 1992		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The grounds that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 31082

DEC 18 1953

92 37087

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Elizabeth BAUGHER				2. DATE OF DEATH MONTH 11 DAY 28 YEAR 92		3. TIME OF DEATH 1230P M	
4. SOCIAL SECURITY NUMBER 218-40-2751		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 10, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1421 Taney Avenue				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Millard Joseph Wilhide				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Virginia Saylor			
19a. INFORMANT'S NAME (Type/Print) Richard L. Baugher				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9920 Kelly Road, Walkersville, Md. 21793			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Glade Cemetery Dec. 2, 1992		20c. LOCATION — City or Town, State Walkersville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Hrap MO0255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE b. DUE TO (OR AS A CONSEQUENCE OF): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE c. DUE TO (OR AS A CONSEQUENCE OF): CHRONIC LE ATRIAL FIBRILLATION d. GAUSTONES							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GAUSTONES							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Gerald Wiman MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 11/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Gerald Wiman MD 310 West Ninth St., Frederick, Md. 21701							
31. DATE FILED (Month, Day, Year) Nov 30 1992				32. REGISTRAR'S SIGNATURE Gerald Wiman-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This is to certify that the death certificate is accurate within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37088

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL DOUGLAS BROWN				2. DATE OF DEATH MONTH DAY YEAR December 8, 1992		3. TIME OF DEATH 10:10 A M	
4. SOCIAL SECURITY NUMBER NONE		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-8-1992	
8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) DARYL L. BROWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) WINDY D. HAYES			
19a. INFORMANT'S NAME (Type/Print) DARYL L. BROWN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) WINCHESTER ST. P.O. BOX 547, PAW PAW, WV 25434			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) CAMP HILL CEMETERY		20c. LOCATION — City or Town, State PAW PAW, WV		20d. DATE 12-15-92	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUNTER-ANDERSON FUNERAL HOME 25411 MERCER ST. BERKELEY SPRINGS, WV			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory insufficiency DUE TO (OR AS A CONSEQUENCE OF): b. Immaturity DUE TO (OR AS A CONSEQUENCE OF): c. 25 to 26 wks immature fetus DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 28193		29d. DATE SIGNED (Month, Day, Year) 12/12/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Moainie 925 Bishop Walsh Road Cumberland, MD. 21502							
31. DATE FILED (Month, Day, Year) JAN 04 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37089

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine Louise Banning				2. DATE OF DEATH MONTH DAY YEAR Dec. 22 1992		3. TIME OF DEATH 9:30 a m	
4. SOCIAL SECURITY NUMBER 213 01 6627		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 18 1902	
8. BIRTHPLACE (State or Foreign Country) W.Va				9a. FACILITY NAME (If not institution, give street and number) Nana's Domicile		9b. CITY, TOWN OR LOCATION OF DEATH Accident	
9c. COUNTY OF DEATH Garrett				10a. STATE Md		10b. COUNTY Garrett	
10c. CITY, TOWN OR LOCATION Kitzmiller				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER E. Main St.	
10f. ZIP CODE 21538				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper		16b. KIND OF BUSINESS/INDUSTRY Lumber	
17. FATHER'S NAME (First, Middle, Last) Robert T. Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Simons			
19a. INFORMANT'S NAME (Type/Print) Kathy Paugh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 332 Kitzmiller, Md 21538			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) IOOF Cemetery		20c. LOCATION — City or Town, State Elk Garden W.Va	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Burdock				22. NAME AND ADDRESS OF FACILITY David A. Burdock FH Kitzmiller, Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Heart Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Atherosclerotic Heart Disease PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							Approximate interval Between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Robert Goralski, MD				29c. LICENSE NUMBER D23979		29d. DATE SIGNED (Month, Day, Year) 12/23/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Goralski, MD, 311 N. 4th Street, Oakland, MD 21550							
31. DATE FILED (Month, Day, Year) DEC 29 1992				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21083

DEC 28 1952

Cole, Edwin L.

92 37090

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edwin L. Cole				2. DATE OF DEATH MONTH 12 DAY 20 YEAR 92		3. TIME OF DEATH 2340 M	
4. SOCIAL SECURITY NUMBER 216-07-4378		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06/29/1913	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 204 St. Matthew Court	
10f. ZIP CODE 21157				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs. College (1-4 or 5+) 4 yrs.			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self-Employed				16b. KIND OF BUSINESS/INDUSTRY Certified Public Accountant			
17. FATHER'S NAME (First, Middle, Last) Edward Cole				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Harvey			
19a. INFORMANT'S NAME (Type/Print) Vernon L. Sullivan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 331, Hampstead, Md. 21074			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremations DATE 12/22			
20c. LOCATION — City or Town, State Hampstead, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Sam Rhythgal			
22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S. Main Street, Hampstead, Md. 21074				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Boardsman				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Colin Davidson Nagam				29c. LICENSE NUMBER D18200		29d. DATE SIGNED (Month, Day, Year) 12/21/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHITRACHEDU NAGAMMA 700A Fosterd Westminster MD 21157				31. DATE FILED (Month, Day, Year) DEC 23 92			
32. REGISTRAR'S SIGNATURE John Davidson - Andell							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37091

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES M. CROCKETT				2. DATE OF DEATH MONTH DAY YEAR Dec. 10, 1992		3. TIME OF DEATH 9:10 A. M.	
4. SOCIAL SECURITY NUMBER 212-10-4701		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 19, 1908	
9a. FACILITY NAME (If not institution, give street and number) Home - 4138 Jacksonville Road				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield, MD		9c. COUNTY OF DEATH Somerset	
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4138 Jacksonville Road				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 6 College (1-4 or 5+) - - -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Private Nurse		16b. KIND OF BUSINESS/INDUSTRY Medical			
17. FATHER'S NAME (First, Middle, Last) George Somers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecil Howard			
19a. INFORMANT'S NAME (Type/Print) Robert L. Crockett (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 a,b,c,d,e,f,g			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park		20c. LOCATION — City or Town, State Crisfield, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma Breast DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 4 yrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M.D. Barhan				29c. LICENSE NUMBER 12764		29d. DATE SIGNED (Month, Day, Year) 12/14/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D. Barhan, M.D. - 4384 Crisfield Highway - Crisfield, MD 21817							
31. DATE FILED (Month, Day, Year) DEC 16 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodwell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

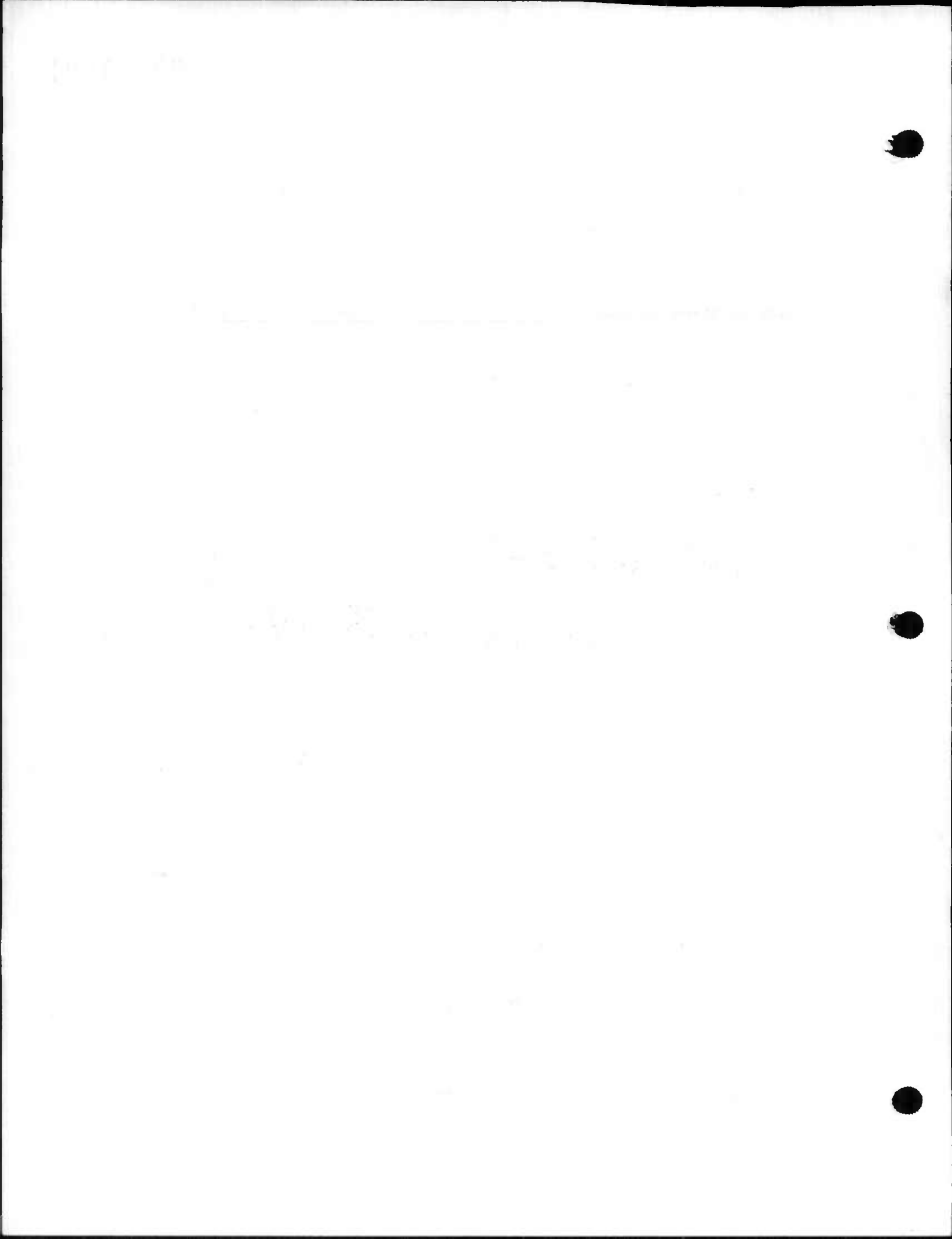
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 is marked, or item 28 is marked, the medical examiner must be notified at once.



92 37092

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Naomi C. Cleary				2. DATE OF DEATH MONTH DAY YEAR 12-9-92		3. TIME OF DEATH 9:35 a. m.	
4. SOCIAL SECURITY NUMBER 195-05-4563		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 23, 1909	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. CITY, TOWN OR LOCATION OF DEATH Crisfield		10. COUNTY OF DEATH Somerset	
11. FACILITY NAME (If not institution, give street and number) Edw. W. McCready Memorial Hospital				12. CITY, TOWN OR LOCATION OF DEATH Crisfield		13. COUNTY OF DEATH Somerset	
14. STATE Maryland		15. COUNTY Somerset		16. CITY, TOWN OR LOCATION Crisfield		17. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
18. STREET AND NUMBER 9 Franklin Lane				19. ZIP CODE 21817		20. CITIZEN OF WHAT COUNTRY? USA	
21. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) Grade 8		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		27. KIND OF BUSINESS/INDUSTRY Clothing			
28. FATHER'S NAME (First, Middle, Last) Vaughn Cleary				29. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Turner			
30. INFORMANT'S NAME (Type/Print) Fay Franklin				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Standard Avenue - Crisfield, MD 21817			
32. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Cemetery - 12/11/92		34. DATE 12/11/92		35. LOCATION — City or Town, State Marion Station, MD	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				37. NAME AND ADDRESS OF FACILITY (21817) Bradshaw & Sons, Main St., Crisfield, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiorespiratory Failure</i>							
Due TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
Due TO (OR AS A CONSEQUENCE OF): <i>Bronchogenic Carcinoma (metastatic)</i>							
Due TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<i>Coronary Heart Failure</i>							
<i>Diabetic Mellitus</i>							
38. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY M		45. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		47. DESCRIBE HOW INJURY OCCURRED					
48. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		49. SIGNATURE AND TITLE OF CERTIFIER N. G. Gill MD		50. LICENSE NUMBER D15215		51. DATE SIGNED (Month, Day, Year) 12.10.92	
52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. William Gill, Rt. #413, Crisfield, Md. 21817							
53. DATE FILED (Month, Day, Year) DEC 16 '92		54. REGISTRAR'S SIGNATURE John Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEPT 82



92 37093

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LENNIE M. Carter				2. DATE OF DEATH MONTH DAY YEAR December 13, 1992		3. TIME OF DEATH 4:23 PM	
4. SOCIAL SECURITY NUMBER 213-16-7105		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 15, 1921	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Md.				10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Deals Island	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER C.D. Deals Island				10f. ZIP CODE 21821		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Sea Food			
17. FATHER'S NAME (First, Middle, Last) Zachari Carter				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Carter			
19a. INFORMANT'S NAME (Type/Print) Shermaine Carter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11282 Princess Anne Md. 21853			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) John Wesley Cem.		20c. LOCATION — City or Town, State Deals Island Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wesley E. Hard F.D.				22. NAME AND ADDRESS OF FACILITY 103 Hampden Ave. Princess Anne Md. 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER C. Stegman MD		29c. LICENSE NUMBER D25219		29d. DATE SIGNED (Month, Day, Year) 12-14-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles D. Stegman MD. R13 Box 3, Princess Anne Md 21858							
31. DATE FILED (Month, Day, Year) DEC 16 '92		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report discusses the general situation of the country and the progress of the work during the year. It also mentions the results of the various investigations and the conclusions drawn from them.

2. The second part of the report deals with the specific details of the work, including the methods used, the results obtained, and the conclusions reached. It also mentions the various difficulties encountered and the ways in which they were overcome.

3. The third part of the report discusses the future work and the plans for the coming year. It also mentions the various resources available and the ways in which they will be used.

4. The fourth part of the report discusses the various other matters of interest, including the results of the various investigations and the conclusions drawn from them.

92 37094

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elizabeth Barnes Cruikshank</i>				2. DATE OF DEATH MONTH DAY YEAR <i>12 22 92</i>		3. TIME OF DEATH <i>2:00 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>220-28-6514</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8/17/08</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Charles Co. Hlt.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>LaPlata MD</i>		9c. COUNTY OF DEATH <i>Charles</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Charles</i>		10c. CITY, TOWN OR LOCATION <i>LaPlata</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>Rt. 488</i>				10f. ZIP CODE <i>20646</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Deputy Register</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Wills State of Maryland</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Frank S. Barnes</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary L. Sanders Barnes</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Alan Cruikshank</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 32, LaPlata, MD. 20646</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Rest Cemetery 12-24-92 LaPlata, MD</i>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David C. Echols</i>				22. NAME AND ADDRESS OF FACILITY <i>AREHART-ECHOLS FUNERAL HOME, INC. LaPlata, MD. 20646</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Cancer Breast</i>							
a. DUE TO (OR AS A CONSEQUENCE OF): <i>Breast Cancer</i>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Osteoporosis Pulmonary Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Barnes</i>				29c. LICENSE NUMBER <i>001009</i>		29d. DATE SIGNED (Month, Day, Year) <i>12-22-92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <i>DEC 23 '92</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 is marked, the medical examiner must be notified at once.

500 COTTON

EMERSON

92 37095

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY FRANCES COLEMAN				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 21, 1992		3. TIME OF DEATH 3:45 AM M	
4. SOCIAL SECURITY NUMBER 407-03-8676		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8 - 28 - 18	
9a. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LAPLATA		9c. COUNTY OF DEATH CHARLES	
10a. STATE Maryland				10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Bryans Road	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER Rt. 1, Box 13 A				10f. ZIP CODE 20616		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contract Negotiator		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Frank Logan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Perrin C. McGinness			
19a. INFORMANT'S NAME (Type/Print) Henry Dewey Coleman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Charles Cemetery		20c. LOCATION — City or Town, State Glymont, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wesley Williams</i>				22. NAME AND ADDRESS OF FACILITY Williams Funeral Home Rt. 225 & Glymont Rd., Indian Head, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Septicemia</i> s. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic Heart Disease</i> <i>Chronic</i> <i>Massive Coronary</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Burke, M.D.</i>		29c. LICENSE NUMBER D-01009		29d. DATE SIGNED (Month, Day, Year) 12-21-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HENRY L. BURKE M.D. 115-A LA GRANGE AVENUE P.O. BOX 591 LA PLATA MD. 20646							
31. DATE FILED (Month, Day, Year) DEC 23 '92		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on this certificate is to be used for the purpose of death certification only. It is not to be used for any other purpose. The death certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37096

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Audra Grace CALLIS				2. DATE OF DEATH MONTH DAY YEAR Dec. 28, 1992		3. TIME OF DEATH 6:00p.m. M	
4. SOCIAL SECURITY NUMBER 219-03-9541		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 10, 1918	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Dennett Road Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Oakland	
9c. COUNTY OF DEATH Garrett				10a. STATE MD		10b. COUNTY Garrett	
10c. CITY, TOWN OR LOCATION Mt. Lake Park				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 607 P St.	
10f. ZIP CODE 21550				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Charles William Short				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Rachel Dugger			
19a. INFORMANT'S NAME (Type/Print) Gary Evans				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 543, Troy, North Carolina 27371			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens 12/31		20c. LOCATION — City or Town, State Oakland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bradley A. Stewart				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal failure							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER H. Johnson				29c. LICENSE NUMBER D27205 D15333		29d. DATE SIGNED (Month, Day, Year) 12/29/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Karl Schwalm, MD 311 N. Fourth St., Oakland, Maryland 21550							
31. DATE FILED (Month, Day, Year) DEC 29 1992				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be retained by the hospital or attending physician. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05 2003

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Vernon D Cosner				2. DATE OF DEATH MONTH DAY YEAR 12 21 1992		3. TIME OF DEATH 11:25A. M							
4. SOCIAL SECURITY NUMBER 212-38-7374		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 17, 1941		8. BIRTHPLACE (State or Foreign Country) West Virginia					
9a. FACILITY NAME (If not institution, give street and number) 4715 Greenhill Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City			9c. COUNTY OF DEATH						
10a. STATE MD		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Baltimore City			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						
10e. STREET AND NUMBER 4715 Greenhill Avenue				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Worker		16b. KIND OF BUSINESS/INDUSTRY Construction									
17. FATHER'S NAME (First, Middle, Last) Calvin Martin Cosner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Onie Helen Aronhalt									
19a. INFORMANT'S NAME (Type/Print) Celia Tyszko				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4828 Hazelwood Ave., Baltimore, MD 21206									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Locust Grove Cemetery		DATE 12/24		20c. LOCATION — City or Town, State Mt. Storm, West Va.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bredy J. Howard				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., oakland, MD 21550									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. FATTY LIVER DUE TO (OR AS A CONSEQUENCE OF): b. CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golig, Jr. MD		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/22/1992							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLIG, JR. MD 111 Penn Street, Baltimore, Maryland 21201													
31. DATE FILED (Month, Day, Year) DEC 24 1992				32. REGISTRAR'S SIGNATURE [Signature]									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Samuel Richard Dunnock				2. DATE OF DEATH MONTH 12 DAY 13 YEAR 1992				3. TIME OF DEATH 7:00P. M			
4. SOCIAL SECURITY NUMBER 213-42-0610		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-17-1894		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 5161 Cordtown Road				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge				9c. COUNTY OF DEATH Dorchester			
10a. STATE Maryland				10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5161 Cordtown Road				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? US					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) William Dunnock				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sallie Trego							
19a. INFORMANT'S NAME (Type/Print) Hazel Kready				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5553 Bonnie Brook Rd. Cambridge, Md 21613							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) E. New Market Cem 12-16		DATE		20c. LOCATION — City or Town, State E. New Market, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiocerebrovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Inquiry		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Dennis L Chute M.D.				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/14/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) DEC 18 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate should be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

17-11-64



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hazel Hook Eckard				2. DATE OF DEATH MONTH 12 DAY 22 YEAR 92		3. TIME OF DEATH 12:30 A M	
4. SOCIAL SECURITY NUMBER 214-01-0482		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5 - 6 - 14	
8. BIRTHPLACE (State or Foreign Country) Baltimore				9. COUNTY OF DEATH Carroll			
10. FACILITY NAME (If not institution, give street and number) 2556 Albert Rill Rd.				11. CITY, TOWN OR LOCATION OF DEATH Westminster		12. COUNTY OF DEATH Carroll	
13. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY Carroll 10c. CITY, TOWN OR LOCATION Westminster				14. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
15. STREET AND NUMBER 2556 Albert Rill Rd.				16. ZIP CODE 21157		17. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: White	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner		24. KIND OF BUSINESS/INDUSTRY The Candy Box			
25. FATHER'S NAME (First, Middle, Last) Carroll E. Hook				26. MOTHER'S NAME (First, Middle, Maiden Surname) Plattie Wimer			
27. INFORMANT'S NAME (Type/Print) William J. Eckard				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2556 Albert Rill Rd. Westminster, Md. 21157			
29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Westminster Cemetery 12/24 Westminster		31. DATE 12/24		32. LOCATION — City or Town, State Westminster	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry K. Fletcher</i>				34. NAME AND ADDRESS OF FACILITY Thomas D. Fletcher & Son F.H. 254 E. Main St. Westminster, Md.			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <u>Instant</u>						36. Approximate Interval Between Onset and Death Instant	
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____						38. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
39. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						40. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
41. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				42. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
43. 28a. DATE OF INJURY (Month, Day, Year)		44. 28b. TIME OF INJURY M		45. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		46. 28d. DESCRIBE NOW INJURY OCCURRED	
47. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				48. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
49. 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vincent N. Nefame</i>				51. 29c. LICENSE NUMBER D 22567		52. 29d. DATE SIGNED (Month, Day, Year) 12/23/92	
53. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 700A Poole Rd, Westminster, MD 21157							
54. 31. DATE FILED (Month, Day, Year) DEC 23 92				55. 32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be completed and signed by the attending physician and completely filled in by the funeral director. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Enos W. Evans				2. DATE OF DEATH MONTH DAY YEAR 12-17-92		3. TIME OF DEATH 4:48p. M	
4. SOCIAL SECURITY NUMBER 231-14-3472		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 1, 1917	
8. FACILITY NAME (If not institution, give street and number) Edw. W. McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset	
9a. FACILITY NAME (If not institution, give street and number)							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Ewell		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4055 Enos Road				10f. ZIP CODE 21824		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8 College (1-4 or 5+) - - -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Boat Captain		16b. KIND OF BUSINESS/INDUSTRY Dept. of Natural Resources State of Maryland	
17. FATHER'S NAME (First, Middle, Last) Woods Evans				18. MOTHER'S NAME (First, Middle, Maiden Surname) Essie Dize			
19a. INFORMANT'S NAME (Type/Print) Phyllis Miley (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4900 Crisfield Highway - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ewell Church Cemetery - 12/20/92		20c. LOCATION — City or Town, State Ewell, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons, Main St., Crisfield, Md. (21817)			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Carcinoma Stomach DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. M. Barhan				29c. LICENSE NUMBER 12764		29d. DATE SIGNED (Month, Day, Year) 12/18/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. Barhan, Rt. #413, Crisfield, Md. 21817							
31. DATE FILED (Month, Day, Year) DEC 22 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Mary Evans				2. DATE OF DEATH MONTH 12 DAY 9 YEAR 92		3. TIME OF DEATH 11:20 a.m.			
4. SOCIAL SECURITY NUMBER 215-05-4415		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 28, 1907			
9a. FACILITY NAME (If not institution, give street and number) Edw. W. McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset			
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 26561 Mariners Road				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) Grade 10 College (1-4 or 5+) — — —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Clothing			
17. FATHER'S NAME (First, Middle, Last) William H. Messick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hester Cannon					
19a. INFORMANT'S NAME (Type/Print) Ruth Brittingham (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27410 Farm Market Road - Marion Station, MD 21838					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park-12/12/92		DATE 12/12/92		20c. LOCATION — City or Town, State Crisfield, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons, Main St., Crisfield, Md. (21817)					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure b. Pneumonia Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. — — — d. — — —								Approximate Interval Between Onset and Death 2W 2W	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Cerebral Vascular Accident						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER James H. Sterling, MD				29c. LICENSE NUMBER D10214		29d. DATE SIGNED (Month, Day, Year) 12/10/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. James Sterling, Main St., Crisfield, Md. 21817									
31. DATE FILED (Month, Day, Year) DEC 15 '92				32. REGISTRAR'S SIGNATURE J. A. Davidson					

10176 SE

Wagon - 1st Floor
Wagon - 2nd Floor

Wagon - 1st Floor
Wagon - 2nd Floor

1

Wagon - 1st Floor
Wagon - 2nd Floor
Wagon - 3rd Floor
Wagon - 4th Floor

92 37102

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CORNELIS ANTONIUS FONTYN				2. DATE OF DEATH MONTH 12 DAY 13 YEAR 92		3. TIME OF DEATH 08:40A	
4. SOCIAL SECURITY NUMBER 232 52 4471		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12 04 22	
8. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MD				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1502 SANFORD RD			
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Meat Cutter		16b. KIND OF BUSINESS/INDUSTRY Retail Food Store			
17. FATHER'S NAME (First, Middle, Last) HENDRIKUS FONTIJN				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHARINA ELIZABETH RUHE			
19a. INFORMANT'S NAME (Type/Print) MRS. THELMA FONTYN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS # 10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Cemetery 12/18/92		20c. LOCATION — City or Town, State ALEX, VA		20d. DATE 12/18/92	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Herbert J. J. J.</i>				22. NAME AND ADDRESS OF FACILITY JOS GAWLERS SONS INC. 5130 WI AVE NW WASHINGTON, D.C. 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 25 DAYS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES - ETHANOLISM - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 11 18 92	
28b. TIME OF INJURY 1830M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Fell down steps			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) #10					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson</i>		29c. LICENSE NUMBER D07089		29d. DATE SIGNED (Month, Day, Year) 12/13/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MAGE 1015 FERNWOOD RD BETHESDA MD 20817 1106							
31. DATE FILED (Month, Day, Year) DEC 15 '92		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET

3



SECRET



92 37103

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Normand Edwin Fetsch				2. DATE OF DEATH MONTH DAY YEAR Dec. 22, 1992		3. TIME OF DEATH 2:30 a m	
4. SOCIAL SECURITY NUMBER 217-03-5629		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1919	
8a. FACILITY NAME (If not institution, give street and number) Baltimore County Gen. Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Randallstown		8c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Reisterstown		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 103 Rockrimmon Road				10f. ZIP CODE 21136		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Dairy	
17. FATHER'S NAME (First, Middle, Last) Nicholas Fetsch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora Premm			
19a. INFORMANT'S NAME (Type/Print) Edna G. Fetsch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Rockrimmon Rd., Reisterstown, Md. 21136			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cem. Dec. 26, 1992		20c. LOCATION — City or Town, State Woodlawn, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel, 11605 Reis. Rd. Owings Mills, Md. 21117			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. acute coronary ischemia with acute pulmonary edema DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval between Onset and Death 2 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. arteriosclerosis Heart disease DUE TO (OR AS A CONSEQUENCE OF):					10 years
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. none							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Manuel Levin M.D.				29c. LICENSE NUMBER D06522		29d. DATE SIGNED (Month, Day, Year) 12/22/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANUEL LEVIN M.D. 6101 Park Hgts Ave, Balto, MD 21215							
31. DATE FILED (Month, Day, Year) DEC 23 '92				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

92 37104

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA H. FARLOW				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 21, 1992		3. TIME OF DEATH 2310 M	
4. SOCIAL SECURITY NUMBER 214-32-0005		6. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02 05 1923	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Princess Anne		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 26420 California Inn Road				10f. ZIP CODE 21853		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Capt. John W. Horner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie E. Timmons			
19a. INFORMANT'S NAME (Type/Print) Mr. Wade Bloodsworth, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 King Richards Ct., Salisbury, Md. 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Asbury U.M. Cemetery		20c. LOCATION — City or Town, State Mt. Vernon, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Liver Failure				Approximate Interval Between Onset and Death 9 days	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Cirrhosis				8 yrs	
		c. Portal Hypertension				10 yrs	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Fibrosis Diabetic retinopathy						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER O. Meadlaw M.D.		29c. LICENSE NUMBER D 19822		29d. DATE SIGNED (Month, Day, Year) 12/22/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 560 Riverside Dr. Salisbury Md 21801							
31. DATE FILED (Month, Day, Year) DEC 23 '92		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



92 37105

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Fraser				2. DATE OF DEATH MONTH 12 DAY 21 YEAR 92		3. TIME OF DEATH 3:22 a	
4. SOCIAL SECURITY NUMBER 081-12-6686		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-24-1900	
8. BIRTHPLACE (State or Foreign Country) Scotland				9a. FACILITY NAME (If not institution, give street and number) Manokin Manor		9b. CITY, TOWN OR LOCATION OF DEATH Princesses Anne	
9c. COUNTY OF DEATH Somerset				10a. STATE Md.		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Princess Anne				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER Edgehill Terrace	
10f. ZIP CODE 21853				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Housewife			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Alexander Cornack				18. MOTHER'S NAME (First, Middle, Maiden Surname) Isabelle Bremner			
19a. INFORMANT'S NAME (Type/Print) Isobel Elliker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 196 Deal Island Md. 21821			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) The Evergreens			
20c. LOCATION — City or Town, State New York, New York				21. SIGNATURE OF FUNERAL SERVICE LICENSEE James L. Herman Sr.			
22. NAME AND ADDRESS OF FACILITY 11673 Somerset Ave Princess Anne, MD 21853				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER C. Hegman MD			
29c. LICENSE NUMBER D25219				29d. DATE SIGNED (Month, Day, Year) 12-21-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) DEC 23 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the cause of death be entered within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The first part of the paper is devoted to a review of the literature on the topic of the paper. The second part is devoted to a description of the experimental setup and the results of the experiments. The third part is devoted to a discussion of the results and the conclusions of the paper.

2. The first part of the paper is devoted to a review of the literature on the topic of the paper. The second part is devoted to a description of the experimental setup and the results of the experiments. The third part is devoted to a discussion of the results and the conclusions of the paper.

92 37106

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry Clement Haywood Sr.				2. DATE OF DEATH MONTH DAY YEAR 12 11 92		3. TIME OF DEATH 17 45 M	
4. SOCIAL SECURITY NUMBER 222-07-4174		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-31-04	
8. BIRTHPLACE (State or Foreign Country) Delaware				9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County		9b. CITY, TOWN OR LOCATION OF DEATH Elkton, Maryland	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland			
10b. COUNTY Cecil				10c. CITY, TOWN OR LOCATION Chesapeake City			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 419 Hemphill St.			
10f. ZIP CODE 21915				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assemblyman		16b. KIND OF BUSINESS/INDUSTRY General Motors Corp Auto Manufacturer			
17. FATHER'S NAME (First, Middle, Last) Joseph NMN Haywood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Hammerer			
19a. INFORMANT'S NAME (Type/Print) Henry Haywood Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Hemphill St. Chesapeake City, Md 21915			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Old Bohemia Cemetery 12-15-92		20c. LOCATION — City or Town, State Warwick, Md		21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King	
22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A. 226 E. Main St. Cecilton, Md 21913		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>aspiration pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>cardiovascular accident</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Kenneth Lewis MD		29c. LICENSE NUMBER D19043-MA		29d. DATE SIGNED (Month, Day, Year) 12/16/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KENNETH LEWIS MD 12 PENNINGTON ST. MIDDLETOWN, MD							
31. DATE FILED (Month, Day, Year) DEC 17 '92		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37107

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM J. HOLLAND				2. DATE OF DEATH MONTH DEC. DAY 17 YEAR 1992		3. TIME OF DEATH 2130 M	
4. SOCIAL SECURITY NUMBER 218-14-1837		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 24, 1920	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Crisfield				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 3 Potomac Street	
10f. ZIP CODE 21817				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II - Army				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H. S. Graduate College (1-4 or 5+) - - -			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Investigator				16b. KIND OF BUSINESS/INDUSTRY MD State Unemployment			
17. FATHER'S NAME (First, Middle, Last) William J. Holland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Daugherty			
19a. INFORMANT'S NAME (Type/Print) David Holland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 J Moss Hill Lane - Salisbury, MD 21801			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park-12/20/92 Crisfield, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Generalized ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 12/18/92			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER E. Kent Carney M.D.				29c. LICENSE NUMBER 00940			
29d. DATE SIGNED (Month, Day, Year) 12/18/92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) E. Kent Carney M.D., 145 E. Carroll Street, Salisbury, MD. 21801			
31. DATE FILED (Month, Day, Year) DEC 22 '92				32. REGISTRAR'S SIGNATURE Julia Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, be filed within 72 hours after death with the State Department of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

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28 91107

92 37108

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Hezekiah HAMILTON				2. DATE OF DEATH MONTH DAY YEAR November 29, 1992		3. TIME OF DEATH 4:20 a m	
4. SOCIAL SECURITY NUMBER 152-01-2934		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 30, 1903	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
9b. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1610 Rock Creek Drive	
10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Real Estate Agent		16b. KIND OF BUSINESS/INDUSTRY Residential/Commercial	
17. FATHER'S NAME (First, Middle, Last) Marmaduke HAMILTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice MAUD			
19a. INFORMANT'S NAME (Type/Print) Mr. Thomas M. Hamilton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 S. Reynolds St., #303, Alexandria VA 22304			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery 12/2/92		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathlyn Robinson</i> M00706				22. NAME AND ADDRESS OF FACILITY Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION (PROBABLE) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. septic (L) KNEE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George I. Smith, Jr. M.D.</i>				29c. LICENSE NUMBER D10587		29d. DATE SIGNED (Month, Day, Year) Nov. 30, 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George I. Smith, Jr., M.D., 300 West 9th Street, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) DEC 2 1992				32. REGISTRAR'S SIGNATURE <i>Julia Robinson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37109

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MYRTLE PHILLIPS HURLEY				2. DATE OF DEATH MONTH 12 DAY 18 YEAR 1992		3. TIME OF DEATH 9:00 P M	
4. SOCIAL SECURITY NUMBER 214-07-7874		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-25-1901	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Glasgow Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Cambridge	
9c. COUNTY OF DEATH Dorchester				10a. STATE Maryland		10b. COUNTY Dorchester	
10c. CITY, TOWN OR LOCATION Cambridge				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 311 Glenburn Ave.	
10f. ZIP CODE 21613				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 2 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) George Addison Phillips				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Anna Rhea			
19a. INFORMANT'S NAME (Type/Print) Arthur S. Parker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Shady Drive Cambridge, Maryland 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dorchester Mem. Park 12-21 Cambridge, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth R. Thomas Jr.				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Atrial Fib DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD s/p Rt hip Fr							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO NA			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) NA 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED NA 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Wayne I Reynolds MD				29c. LICENSE NUMBER MD H43598		29d. DATE SIGNED (Month, Day, Year) 12/18/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wayne I Reynolds 503 Byron St Cambridge, Md 21613							
31. DATE FILED (Month, Day, Year) DEC 23 '92				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is checked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Moffett Ivens				2. DATE OF DEATH MONTH DAY YEAR December 17 1992		3. TIME OF DEATH 7:05 AM	
4. SOCIAL SECURITY NUMBER 166 01 0355		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 10, 1911	
8a. FACILITY NAME (If not institution, give street and number) The Kent and Queen Anne's Hospital, Inc.				8b. CITY, TOWN OR LOCATION OF DEATH Chestertown		8c. COUNTY OF DEATH Kent	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Rock Hall		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5799 Beach Road				10f. ZIP CODE 21661		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Yes Navy		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) V. Pres. Management		15b. KIND OF BUSINESS/INDUSTRY Textiles			
17. FATHER'S NAME (First, Middle, Last) Frank Ivens				16. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Fogwell			
19a. INFORMANT'S NAME (Type/Print) The Deceased While living				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rock Hall, Md. 21620			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Cemetery (12/19/92)		20c. LOCATION — City or Town, State Oaks, Pa. Montgomery CO			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Willis Wells</i>				22. NAME AND ADDRESS OF FACILITY Fellows - Wells 413 High St. Chestertown, Md. 21620			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardiac arrest							
Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
Due to (or as a consequence of): acute myocardial infarction							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John C. Seymour</i>				29c. LICENSE NUMBER D-13824		29d. DATE SIGNED (Month, Day, Year) 12-17-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John C. Seymour (D 13824) Chestertown, Md. 21620							
31. DATE FILED (Month, Day, Year) DEC 18 92				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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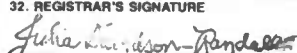
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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry Clay James				2. DATE OF DEATH MONTH 12 DAY 01 YEAR 92		3. TIME OF DEATH 1355 P M	
4. SOCIAL SECURITY NUMBER 488-26-9955		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 3, 1925	
8. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5738 Sunset View Lane				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) librarian		16b. KIND OF BUSINESS/INDUSTRY federal government			
17. FATHER'S NAME (First, Middle, Last) Henry Clay James				18. MOTHER'S NAME (First, Middle, Maiden Surname) Norine Flynn			
19a. INFORMANT'S NAME (Type/Print) Richard James				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1196 Willoughby Ct., Frederick, Md. 21701			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 12/4		DATE Frederick, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC ADENOCARCINOMA, PRIMARY UNKNOWN							
Approximate Interval Between Onset and Death 3 MONTHS							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James L. Roessler MD				29c. LICENSE NUMBER D20488		29d. DATE SIGNED (Month, Day, Year) 12-3-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES L. ROESSLER MD PO Box 17 MIDDLETOWN, MD. 21769							
31. DATE FILED (Month, Day, Year) DEC 7 1992				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Laura R. H. JACOBY				2. DATE OF DEATH MONTH DAY YEAR December 1, 1992		3. TIME OF DEATH 4:00 P.M.	
4. SOCIAL SECURITY NUMBER 577-24-4581		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 15, 1902	
9a. FACILITY NAME (If not institution, give street and number) Homewood Retirement Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 31 West Patrick Street			
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 + College (1-4 or 5+) 5 +				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		16b. KIND OF BUSINESS/INDUSTRY Hospital	
17. FATHER'S NAME (First, Middle, Last) Lloyd Duvall Roelke				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Rebecca Dorsey			
19a. INFORMANT'S NAME (Type/Print) Mrs. Doris Gaither				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Lindberg Court, Frederick, Md. 21701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery, 12-5-92		20c. LOCATION — City or Town, State Frederick, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Allan H Ruby MO0703	
22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of rectum Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. A. Austin Pearre				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/2/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. A. Austin Pearre, 300 West Ninth Street, Frederick, Md. 21701							
31. DATE FILED (Month, Day, Year) DEC 4 1992				32. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, to be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NANCY LURTON				2. DATE OF DEATH MONTH 12 - DAY 10 - YEAR 92		3. TIME OF DEATH 0632 M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11 04 43		8. BIRTHPLACE (State or Foreign Country) Roanoke, VA
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MD				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 5004 SCARSDALE RD			
10f. ZIP CODE 20816				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Designer		16b. KIND OF BUSINESS/INDUSTRY Interior Design			
17. FATHER'S NAME (First, Middle, Last) Laidler Mackall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Taylor			
19a. INFORMANT'S NAME (Type/Print) Horace V. Lurton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5004 Scarsdale Rd., Bethesda, MD 20816			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Crematory		DATE 12/11		20c. LOCATION — City or Town, State Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael E. Nelson				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 16 HRS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12 9 92		28b. TIME OF INJURY 2330 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED FELL DOWN 13 STEPS		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) #10			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Francis C. Mayle				29c. LICENSE NUMBER D07094		29d. DATE SIGNED (Month, Day, Year) 12-10-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print) FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817							
31. DATE FILED (Month, Day, Year) DEC 14 '92		32. REGISTRAR'S SIGNATURE John Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any indicator of a traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37114

1. DECEDENT'S NAME (First, Middle, Last) Paul Randolph Scott Leatherwood				2. DATE OF DEATH MONTH DAY YEAR 12 22 92		3. TIME OF DEATH 12:10 P M					
4. SOCIAL SECURITY NUMBER 217073473		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-2-04		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Carroll County Gen Hosp				9b. CITY, TOWN OR LOCATION OF DEATH Westminster MD			9c. COUNTY OF DEATH Carroll				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 68 Timber Ridge Drive		10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sausage Maker		16b. KIND OF BUSINESS/INDUSTRY William F. Myers & Sons					
17. FATHER'S NAME (First, Middle, Last) Perry Scott Leatherwood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence M. Lawyer							
19a. INFORMANT'S NAME (Type/Print) Paul R.S. Leatherwood Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1037 Wheatstone Dr. Mishawaka, Indiana 46544							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Valley		DATE 12/27		20c. LOCATION — City or Town, State Pleasant Valley Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Nancy Fletcher				22. NAME AND ADDRESS OF FACILITY Thomas D. Fletcher & Son F.H. 254 E. Main St. Westminster, Md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Bowel Gangrene DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2 wks			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER James H. Law MD				29c. LICENSE NUMBER 041092		29d. DATE SIGNED (Month, Day, Year) 12/27/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rakesh Chawla Carroll County Gen Hosp. Westminster, MD											
31. DATE FILED (Month, Day, Year) DEC 23 92				32. REGISTRAR'S SIGNATURE John Davidson-Randall							

92 37115

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HETTIE A LENTZ				2. DATE OF DEATH MONTH 12 DAY 08 YEAR 92		3. TIME OF DEATH 1345 M	
4. SOCIAL SECURITY NUMBER 228-34-8993		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-07-21	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1009 Fairground Drive - Apt. 1				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Employee		16b. KIND OF BUSINESS/INDUSTRY Food Processing			
17. FATHER'S NAME (First, Middle, Last) William Harvey Thomas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor Denson			
19a. INFORMANT'S NAME (Type/Print) Judy Potts (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Clyde Avenue - Fruitland, MD 21826			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Cemetery - 12/11/92		20c. LOCATION — City or Town, State Marion Station, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. COMPLICATING MEDICAL PROCEDURE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR OCCLUSIVE DISEASE CHRONIC HEMORRHOIDAL OBSTRUCTIVE PULMONARY DISEASE						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER JOHN T. BULKELEY, M.D., DEPUTY M.E.				29c. LICENSE NUMBER D03599		29d. DATE SIGNED (Month, Day, Year) 12-09-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MARYLAND, 21801							
31. DATE FILED (Month, Day, Year) DEC 14 '92		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

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92 37116

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Betty H. Lindner				2. DATE OF DEATH Dec. 11, 1992 YEAR		3. TIME OF DEATH 4:41 P. M.	
4. SOCIAL SECURITY NUMBER 057-46-0227		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) 3-17-1916		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
10a. STATE Maryland				10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Accident	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 10 Trailer Court Rd.				10f. ZIP CODE 21520		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY own Home			
17. FATHER'S NAME (First, Middle, Last) Gustave Hayen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilhelmina Mueller			
19a. INFORMANT'S NAME (Type/Print) William H. Lindner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 184, Accident, MD 21520			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Zion Cemetery		20c. LOCATION — City or Town, State 12-15 Accident, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>S. Lindner</i>				22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A., 155 Main St. Grantsville, MD 21536			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypothermia</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. <i>Possible Sepsis vs CVA.</i> c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Todd Tritch</i>		29c. LICENSE NUMBER D39314		29d. DATE SIGNED (Month, Day, Year) 12/12/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Todd Tritch, M.D., Garrett Co. Medical Group, N. 4th St., Oakland, MD 21550							
31. DATE FILED (Month, Day, Year) DEC 18 1992		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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92 37117

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Levin L. Maddox				2. DATE OF DEATH MONTH 12 DAY 19 YEAR 92		3. TIME OF DEATH 8:49 p. m.	
4. SOCIAL SECURITY NUMBER 219-14-4444		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) April-23-1914	
9a. FACILITY NAME (If not institution, give street and number) Edw. W. McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset	
10a. STATE Md.				10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Kingston	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER Box 5 Crisfield		10f. ZIP CODE 21817	
10g. CITIZEN OF WHAT COUNTRY? U.S.				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) LABORER				16b. KIND OF BUSINESS/INDUSTRY SEAFOOD			
17. FATHER'S NAME (First, Middle, Last) Orlando Maddox				18. MOTHER'S NAME (First, Middle, Maiden Surname) LORIE Maddox			
19a. INFORMANT'S NAME (Type/Print) Elton Maddox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6626 Crisfield Hyway 21838			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maddox Cemetery 12-23-92 Kingston Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony Ward</i>				22. NAME AND ADDRESS OF FACILITY Anthony Ward, 314 Cove St., Crisfield, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. J. Barhan				29c. LICENSE NUMBER 12764		29d. DATE SIGNED (Month, Day, Year) 12/21/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. Barhan, Rt. #413, Crisfield, Md. 21817							
31. DATE FILED (Month, Day, Year) DEC 22 '92				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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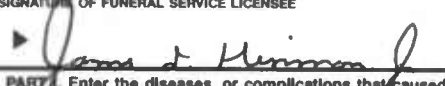


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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMIL A. MONZEGLIO				2. DATE OF DEATH MONTH 12 DAY 15 YEAR 92		3. TIME OF DEATH 0610 AM	
4. SOCIAL SECURITY NUMBER 003-33-2385		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/17/1900	
8. BIRTHPLACE (State or Foreign Country) Italy				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Westover				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 25724 Drum Point Rd.	
10f. ZIP CODE 21871				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) farmer		16b. KIND OF BUSINESS/INDUSTRY agriculture	
17. FATHER'S NAME (First, Middle, Last) Bartholomew Monzeglio				18. MOTHER'S NAME (First, Middle, Maiden Surname) Delphina Monzeglio			
19a. INFORMANT'S NAME (Type/Print) Lewis Monzeglio				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drum Point Rd., Westover, Md. 21871			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory 12/15		20c. LOCATION — City or Town, State Salisbury, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home 11673 Somerset Ave., Princess Anne, Md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLOON CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BOWEL OBSTRUCTION DUE TO ADHESIONS ACUTE MYOCARDIAL INFARCTION, CHF PNEUMONIA							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D36576		29d. DATE SIGNED (Month, Day, Year) 12/15/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RONALD P. TRAUTMAN 560 RIVERSIDE DR SALISBURY MD 21801							
31. DATE FILED (Month, Day, Year) DEC 17 '92				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on this death certificate is to be retained by the hospital or attending physician. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

GROUP 1

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92 37119

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA G. MADDRIX				2. DATE OF DEATH MONTH DAY YEAR Dec. 12, 1992		3. TIME OF DEATH 9:03 A. M.	
4. SOCIAL SECURITY NUMBER 219-26-2144		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 9, 1934	
9a. FACILITY NAME (If not institution, give street and number) Home - 28324 Farm Market Road				9b. CITY, TOWN OR LOCATION OF DEATH Marion Station, MD		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Marion Station		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 28324 Farm Market Road				10f. ZIP CODE 21838		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Joseph Dujardin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Heim			
19a. INFORMANT'S NAME (Type/Print) Elwood F. Maddrix (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 a,b,c,d,e,f,g			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park		20c. LOCATION — City or Town, State Crisfield, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Sterling, M.D.</i>				29c. LICENSE NUMBER D 10214		29d. DATE SIGNED (Month, Day, Year) Dec. 14, 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Sterling, M.D. - 320 W. Main St. - Crisfield, MD 21817							
31. DATE FILED (Month, Day, Year) DEC 15 '92		32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37120

1. DECEDENT'S NAME (First, Middle, Last) Warren Frederick METHENY				2. DATE OF DEATH MONTH 12 DAY 13 YEAR 92		3. TIME OF DEATH 8:55 A M			
4. SOCIAL SECURITY NUMBER 234-12-0652		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 30, 1914		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) U. OF MD MEDICAL SYSTEM				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH Baltimore		
10a. STATE Maryland		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER Rt. 7 Box 1080				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assemblyman		15b. KIND OF BUSINESS/INDUSTRY Auto Manufacture					
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rheua ————— Metheny					
19a. INFORMANT'S NAME (Type/Print) Mary J. Metheny				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 7 Box 1080 Oakland, Maryland @1550					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens 12/16		20c. LOCATION — City or Town, State Oakland Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Franklin H. Carter				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 South Second Street Oakland, MD 21550					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEMORRHAGE FROM BOWELS DUE TO (OR AS A CONSEQUENCE OF): b. MESENTERIC ISCHEMIA DUE TO (OR AS A CONSEQUENCE OF): c. MULTIPLE EMBOLI DUE TO (OR AS A CONSEQUENCE OF): d. PATIAL FIBRILLATION Approximate Interval Between Onset and Death 2 1/2 hrs 1 MONTH 1 MONTH CHRONIC									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Sadi MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/13/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL SADI UMMS									
31. DATE FILED (Month, Day, Year) DEC 15 1992				32. REGISTRAR'S SIGNATURE [Signature]					

02020 92

92 37121

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BEVERLY JEAN MILLER				2. DATE OF DEATH MONTH 11 DAY 30 YEAR 1992		3. TIME OF DEATH 0214a M	
4. SOCIAL SECURITY NUMBER 217-42-9342		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 4, 1942	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH FREDERICK	
9c. COUNTY OF DEATH FREDERICK				10a. STATE MARYLAND		10b. COUNTY FREDERICK	
10c. CITY, TOWN OR LOCATION THURMONT				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12606 CATOCTIN FURNACE RD.	
10f. ZIP CODE 21788				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY PRODUCTION & ENGINEERING			
17. FATHER'S NAME (First, Middle, Last) CLINTON EDGAR MILLER				18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA JOSEPHINE CARTY			
19a. INFORMANT'S NAME (Type/Print) PATRICIA JOANN MILLER (SISTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12606 CATOCTIN FURNACE RD., THURMONT, MD 21788			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RESTHAVEN MEMORIAL GARDENS 12/2		20c. LOCATION — City or Town, State FREDERICK, MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN ST., THURMONT, MD 21788				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PROGRESSIVE MULTIPLE MYELOMA Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST MALIGNANT ASCITES HEPATIC FAILURE			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D31761		29d. DATE SIGNED (Month, Day, Year) 11/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN M. O'CONNOR, MD 581 W. SEVENTH ST. FREDERICK, MD							
31. DATE FILED (Month, Day, Year) DEC 2 1992				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37122

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roland Marion Martin				2. DATE OF DEATH MONTH DAY YEAR Nov. 28, 1992		3. TIME OF DEATH 7:10 P. M.	
4. SOCIAL SECURITY NUMBER 427-18-2747		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 28, 1908	
9a. FACILITY NAME (If not institution, give street and number) Collingswood Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 299 Hurley Ave.				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor		16b. KIND OF BUSINESS/INDUSTRY Painting			
17. FATHER'S NAME (First, Middle, Last) Martin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Reese			
19a. INFORMANT'S NAME (Type/Print) Margaret M. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Middleboro Ct., Damascus, Md. 20872			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium Inc.		DATE Bethesda, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Olin L. Molesworth				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → chronic renal failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST atherosclerosis PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. aortic stenosis							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John R. Melnick				29c. LICENSE NUMBER D19294		29d. DATE SIGNED (Month, Day, Year) Nov. 29, 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John R. Melnick, M.D. 911 Russell Ave., Gaithersburg, Md. 20879							
31. DATE FILED (Month, Day, Year) Nov 30 1992		32. REGISTRAR'S SIGNATURE John R. Melnick					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37123

1. DECEDENT'S NAME (First, Middle, Last) Anna Marie MATTHEWS				2. DATE OF DEATH MONTH DAY YEAR 12 23 1992		3. TIME OF DEATH 3:15 p m			
4. SOCIAL SECURITY NUMBER 163-22-8711		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 16, 1919		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland			9c. COUNTY OF DEATH Garrett		
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER Rt. 1, Box 7582				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Michael ----- Varbel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary ----- Karabin					
19a. INFORMANT'S NAME (Type/Print) James E. Matthews, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 7582, Oakland, Maryland 21550					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens 12/27		20c. LOCATION — City or Town, State Oakland, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septicemia DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma of the Ovary DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death One Week Unknown			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Adult onset Diabetes Mellitus						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D 05658		29d. DATE SIGNED (Month, Day, Year) December 25, 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland 21550									
31. DATE FILED (Month, Day, Year) DEC 29 1992				32. REGISTRAR'S SIGNATURE 					

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Handwritten initials or signature.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUSSELL ELLIOTT OVERS III				2. DATE OF DEATH MONTH 12 DAY 16 YEAR 92		3. TIME OF DEATH 11:04 P.M.	
4. SOCIAL SECURITY NUMBER 212-373995		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 5 MONTHS 5 DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 7-7-1992	
8. BIRTHPLACE (State or Foreign Country) MD.				9. FACILITY NAME (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL			
10. CITY, TOWN OR LOCATION OF DEATH FREDERICK				11. COUNTY OF DEATH FREDERICK			
12a. STATE MD.		12b. COUNTY Frederick		12c. CITY, TOWN OR LOCATION Frederick		12d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
13a. STREET AND NUMBER 6960 Exeter Court, Apt. 206				13b. ZIP CODE 21701		13c. CITIZEN OF WHAT COUNTRY? USA	
14. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		17. RACE — American Indian, Black, White, etc. Specify: black/white	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) n/a		20. KIND OF BUSINESS/INDUSTRY n/a			
21. FATHER'S NAME (First, Middle, Last) Russell Elliott Overs, Jr.				22. MOTHER'S NAME (First, Middle, Maiden Surname) Anne Idoni			
23. INFORMANT'S NAME (Type/Print) Russell Elliott Overs, Jr.				24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6960 Exeter Ct., Apt. 206, Frederick, Md. 21701			
25a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		25b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 12/20/92		25c. LOCATION — City or Town, State Frederick, Md.		26. SIGNATURE OF FUNERAL SERVICE LICENSEE Honda L Lemmer	
27. NAME AND ADDRESS OF FACILITY STAUFFER FUNERAL HOME, P.O. BOX 1819 Frederick, Maryland 21702		28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BLUNT FORCE INJURIES OF ABDOMEN DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
29. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				30. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		31. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
32. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		33. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
34. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		35a. DATE OF INJURY (Month, Day, Year) 12-16-92		35b. TIME OF INJURY 10:00 P.M.		35c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
35d. DESCRIBE HOW INJURY OCCURRED SUBJECT BEATEN		35e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: HOME		35f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6960 Exeter Court, Frederick, Maryland			
36. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
37. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD				38. LICENSE NUMBER O.C.M.E.		39. DATE SIGNED (Month, Day, Year) 12-18-1992	
40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
41. DATE FILED (Month, Day, Year) JAN 04 1993		42. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37125

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARJORIE ROWENA OLSON				2. DATE OF DEATH MONTH 12 DAY 3 YEAR 92		3. TIME OF DEATH 1410 P M		
4. SOCIAL SECURITY NUMBER 079-09-4600		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-6-1912		
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT								
10a. STATE N. Y.		10b. COUNTY Westchester		10c. CITY, TOWN OR LOCATION Pottersville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER Star Route River Road				10f. ZIP CODE 12860		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY n/a				
17. FATHER'S NAME (First, Middle, Last) Halstead				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lilu Wood				
19a. INFORMANT'S NAME (Type/Print) Shirley Merando				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Wyndale Ct., Walkersville, Md. 21793				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 12/4/92		20c. LOCATION — City or Town, State Smithsburg, Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Handa L Lemmer				22. NAME AND ADDRESS OF FACILITY STAUFFER FUNERAL HOME, P.O. BOX 1819 Frederick, Maryland 21702				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SMALL CELL LUNG CANCER Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. </div> <div style="border: 1px solid black; padding: 5px;"> Approximate Interval Between Onset and Death 1 MONTH </div> </div>								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE LEFT UPPER LOBE PNEUMONIA CHRONIC MYELOMONOCYTIC LEUKEMIA							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Brian M. O'Connor				29c. LICENSE NUMBER D31761		29d. DATE SIGNED (Month, Day, Year) 12/3/92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST. FREDERICK MD 21701								
31. DATE FILED (Month, Day, Year) DEC 7 1992		32. REGISTRAR'S SIGNATURE John A. Mason-Hendall						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health, Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37126

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH ELIZABETH PARKS						2. DATE OF DEATH MONTH DAY YEAR 12 9 92		3. TIME OF DEATH 7:02 PM	
4. SOCIAL SECURITY NUMBER 213-24-0429		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09 07 1904		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Peninsula Regional Medical Ctr. Salisbury						9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Princess Anne				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11974 Edgehill Terrace				10f. ZIP CODE 21853		10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) Thomas Heath						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae McDaniel			
19a. INFORMANT'S NAME (Type/Print) Gladys Bishop				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1956 Pineway, Salisbury, Md. 21801					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Peters UM Cemetery			20c. LOCATION — City or Town, State Oriole, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Hinson</i> MO0295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiovascular my arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hemorrhagic cystitis</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Gastritis (Hx of UGI bleeding - hematemesis)</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Vertebrolusum (Hx of Fracture)</i>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. C. Hill MD</i>						29c. LICENSE NUMBER D15881		29d. DATE SIGNED (Month, Day, Year) 12-10-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>E. C. Hill MD, Hinman Funeral Home, Princess Anne, MD</i>									
31. DATE FILED (Month, Day, Year) DEC 11 '92				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows injury, or other traumatic event, the medical examiner must be notified at once.

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92 37127

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ida Elizabeth PYLES				2. DATE OF DEATH MONTH DAY YEAR Dec. 26, 1992		3. TIME OF DEATH 1:35 A M	
4. SOCIAL SECURITY NUMBER 235-79-7988		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 21, 1917	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital			
10. CITY, TOWN OR LOCATION OF DEATH Oakland				11. COUNTY OF DEATH Garrett			
12. RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY Garrett 10c. CITY, TOWN OR LOCATION Oakland 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				13. STREET AND NUMBER Rt. 4, Box 5080 10f. ZIP CODE 21550 10g. CITIZEN OF WHAT COUNTRY? USA			
14. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		15. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		17. RACE — American Indian, Black, White, etc. Specify: White	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4 or 5+) 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker 16b. KIND OF BUSINESS/INDUSTRY Home		19. FATHER'S NAME (First, Middle, Last) Joseph ----- O'Brien		20. MOTHER'S NAME (First, Middle, Maiden Surname) Lula ----- Taylor		21. INFORMANT'S NAME (Type/Print) Eugene Pyles	
22. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Bayard Cemetery		24. DATE 2/28		25. LOCATION — City or Town, State Bayard, West Virginia	
26. SIGNATURE OF FUNERAL SERVICE LICENSEE Bradley H. Stewart				27. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): years Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. aortic and mitral valve disease DUE TO (OR AS A CONSEQUENCE OF): years c. atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): years d.							
29. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD, diabetes type 2, hypertension							
30. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		31. HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		32. OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		33. PLACE OF DEATH (Check only one)	
34. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		35. DATE OF INJURY (Month, Day, Year)		36. TIME OF INJURY M		37. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		39. DESCRIBE HOW INJURY OCCURRED					
40. LOCATION (Street and Number or Rural Route Number, City or Town, State)		41. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
42. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
43. SIGNATURE AND TITLE OF CERTIFIER Margaret A. Kaiser				44. LICENSE NUMBER D26650		45. DATE SIGNED (Month, Day, Year) 12/27/92	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margaret Kaiser, M.D., P.O. Box 486 Oakland, Md 21550							
47. DATE FILED (Month, Day, Year) DEC 29 1992		48. REGISTRAR'S SIGNATURE					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

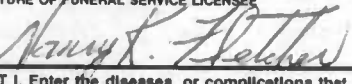
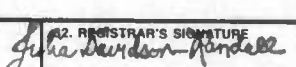
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) John S. Riggleman				2. DATE OF DEATH MONTH 12 DAY 22 YEAR 92				3. TIME OF DEATH 6:17A M					
4. SOCIAL SECURITY NUMBER 234-42-9303				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-11-28		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) VA Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore					
RESIDENCE OF DECEDENT													
10a. STATE West Va.				10b. COUNTY Hardy				10c. CITY, TOWN OR LOCATION Fisher				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER HC 85 Box 3						10f. ZIP CODE 26818		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean War-Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Supt.				16b. KIND OF BUSINESS/INDUSTRY Hestess Industrial					
17. FATHER'S NAME (First, Middle, Last) Claude Riggleman						18. MOTHER'S NAME (First, Middle, Maiden Surname) Vertie Mongold							
19a. INFORMANT'S NAME (Type/Print) Catherine Bobo Riggleman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 85 Box 3 Fisher, West Va. 26818									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Newhouse Cemetery 12/27/92				20c. LOCATION — City or Town, State Rig, West Va.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas D. Fletcher & Son F.H. 254 E. Main St. Westminster, Md.									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-pulmonary arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. congestive heart failure c. myocardial disease d. severe 3 vessel coronary artery disease										Approximate Interval Between Onset and Death Immediate years years years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure, cholelithiasis, poor surgical candidate										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) _____		28b. TIME OF INJURY _____ M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED _____			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER E. Sneed, MD						29c. LICENSE NUMBER 12107		29d. DATE SIGNED (Month, Day, Year) 12/22/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) _____													
31. DATE FILED (Month, Day, Year) DEC 23 92				32. REGISTRAR'S SIGNATURE 									

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Susan F. Ruark				2. DATE OF DEATH MONTH 12 DAY 19 YEAR 92		3. TIME OF DEATH 2:35 P.M.	
4. SOCIAL SECURITY NUMBER 217-16-9948		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 6, 1906	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Alice Byrd Tawes Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Crisfield, MD		9c. COUNTY OF DEATH Somerset	
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 403 Charlotte Avenue				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) Unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) William Fox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mollie G. Tull			
19a. INFORMANT'S NAME (Type/Print) Frank L. Collins, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Hall Highway (Tawes Nursing Home) MD 21817			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory - 12/21/92		20c. LOCATION — City or Town, State Salisbury, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Chronic Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. A. Sterling, M.D.				29c. LICENSE NUMBER D10214		29d. DATE SIGNED (Month, Day, Year) 12/21/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Sterling, M.D. - 320 W. Main St. - Crisfield, MD 21817							
31. DATE FILED (Month, Day, Year) DEC 22 '92				32. REGISTRAR'S SIGNATURE John H. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the cause certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by a funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRIETTA ELIZABETH RISОВI				2. DATE OF DEATH MONTH DAY YEAR 11 - 29 - 92		3. TIME OF DEATH 0350 M	
4. SOCIAL SECURITY NUMBER 245-03-5314		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 30, 1907	
8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA				9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10. RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Thurmont		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 10801 Utica Mills Ct.				10f. ZIP CODE 21788		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor - Retail		16b. KIND OF BUSINESS/INDUSTRY Retail Department Store			
17. FATHER'S NAME (First, Middle, Last) BARTLETT ALFONSO FERGUSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) HARIET E. SCROGGS			
19a. INFORMANT'S NAME (Type/Print) BOBBY G. PERRY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10801 Utica Mills Cr. / Thurmont, Md. 21788			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MORAVIAN FALLS CEMETERY		20c. LOCATION — City or Town, State MORAVIAN FALLS, N. CAROLINA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Peterson</i>				22. NAME AND ADDRESS OF FACILITY STAUFFER FUNERAL HOME 1621 Opossumtown Pike/Frederick, Md. 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arthritis</i> <i>Dyslipidemia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Anderson</i>				29c. LICENSE NUMBER 1722141		29d. DATE SIGNED (Month, Day, Year) 11/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John H. Anderson</i> 1425 Lang Ave. Frederick Md							
31. DATE FILED (Month, Day, Year) DEC 2 1992				32. REGISTRAR'S SIGNATURE <i>John H. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After completion has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lora Ruark Robinson				2. DATE OF DEATH MONTH DAY YEAR Dec 19, 1992				3. TIME OF DEATH 6:15 A M			
4. SOCIAL SECURITY NUMBER 219-14-4525				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/3/1918		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 437 Oakley Street						9b. CITY, TOWN OR LOCATION OF DEATH Cambridge			9c. COUNTY OF DEATH Dorchester		
RESIDENCE OF DECEDENT											
10a. STATE Maryland			10b. COUNTY Dorchester			10c. CITY, TOWN OR LOCATION Cambridge			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 437 Oakley Street						10f. ZIP CODE 21613			10g. CITIZEN OF WHAT COUNTRY? US		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seafood Worker				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Richard Ruark						18. MOTHER'S NAME (First, Middle, Maiden Surname) Geneva Sullender					
19a. INFORMANT'S NAME (Type/Print) John P. Robinson, Sr.						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 437 Oakley St. Cambridge, Md. 21613					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dorchester Mem. Park 12/22				20c. LOCATION — City or Town, State Cambridge, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Liver metastases DUE TO (OR AS A CONSEQUENCE OF): Colon Ca Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D53622			29d. DATE SIGNED (Month, Day, Year) 12-22-92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Craig W. Caldwell, Dorchester Gen Hosp, Cambridge, MD											
31. DATE FILED (Month, Day, Year) DEC 22 '92				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT JOHN RUCKERT				2. DATE OF DEATH MONTH 12 DAY 22 YEAR 1992		3. TIME OF DEATH 11:00 a M	
4. SOCIAL SECURITY NUMBER 217-01-6219		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 13, 1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 381 N. Bradley Lane		9b. CITY, TOWN OR LOCATION OF DEATH Oakland	
9c. COUNTY OF DEATH Garrett				10a. STATE Maryland		10b. COUNTY Garrett	
10c. CITY, TOWN OR LOCATION Oakland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 381 N. Bradley Lane	
10f. ZIP CODE 21550				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Real Estate Agent		16b. KIND OF BUSINESS/INDUSTRY Real Estate	
17. FATHER'S NAME (First, Middle, Last) Lawrence H. Ruckert				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Tudor			
19a. INFORMANT'S NAME (Type/Print) Robert B. Sincell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 I Street Mt. Lake Park, Md. 21550			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oakland Cemetery		20c. LOCATION — City or Town, State 12/26 Oakland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert H. Durst</i> M00167				22. NAME AND ADDRESS OF FACILITY P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Ventricular Arrhythmia, Acute							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Cardiomyopathy with Congestive Failure							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Arteriosclerotic Cardio-Vascular Disease							
DUE TO (OR AS A CONSEQUENCE OF):							
d. Unknown							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) Dec. 22, 1992		28b. TIME OF INJURY 11:00a M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED Fell in front of his home at the moment of his death			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 325 Bradley Lane Oakland, Maryland 21550			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Herbert H. Leighton M.D.</i>				29c. LICENSE NUMBER D 05658		29d. DATE SIGNED (Month, Day, Year) Dec. 23, 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland 21550							
31. DATE FILED (Month, Day, Year) DEC 28 1992				32. REGISTRAR'S SIGNATURE <i>John L. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 25 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

41VA copy

05 91135

92 37133

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARTHA V STANSBURY				2. DATE OF DEATH MONTH DAY YEAR December 16 1992				3. TIME OF DEATH 11:24 A.M.			
4. SOCIAL SECURITY NUMBER 214-32-1977				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 29/1911		8. BIRTHPLACE (State or Foreign Country) MD.	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital at Easton						9b. CITY, TOWN OR LOCATION OF DEATH Easton				9c. COUNTY OF DEATH Talbot	
RESIDENCE OF DECEDENT											
10a. STATE MD		10b. COUNTY QUEEN ANNES				10c. CITY, TOWN OR LOCATION CENTREVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER R. f. 7						10f. ZIP CODE 21617		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) Elem.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABOR				16b. KIND OF BUSINESS/INDUSTRY VARIOUS			
17. FATHER'S NAME (First, Middle, Last) ARTHUR W. STANSBURY						18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGINIA CAIN					
19a. INFORMANT'S NAME (Type/Print) MRS. VIOLET BOCHOSTER R.F.D. CENTREVILLE, MD - 21617						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth Wally						22. NAME AND ADDRESS OF FACILITY 207 CALVERT ST. CHESTER TOWN, MD - 21620					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Substernal goiter BRPR 1:32 HTN											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Michael Lees				29c. LICENSE NUMBER D42005		29d. DATE SIGNED (Month, Day, Year) 12/16/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 400 Melvin Ave, Queenstown, MD 21601											
31. DATE FILED (Month, Day, Year) DEC 21 '92				32. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37134

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Alden Bernard Summers.</u>				2. DATE OF DEATH MONTH <u>11</u> DAY <u>28</u> YEAR <u>92</u>		3. TIME OF DEATH <u>4 A</u> M	
4. SOCIAL SECURITY NUMBER <u>214-10-2948</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <u>76</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Oct. 13, 1916</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>							
9a. FACILITY NAME (If not institution, give street and number) <u>Frederick Memorial Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Frederick</u>		9c. COUNTY OF DEATH <u>Frederick</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Frederick</u>		10c. CITY, TOWN OR LOCATION <u>Frederick</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>22 East Ninth Street</u>				10f. ZIP CODE <u>21701</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11 years</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Traffic Mgr.</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Everedy Company Kitchen Utensil</u>			
17. FATHER'S NAME (First, Middle, Last) <u>William E. Summers</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Iva M. Perry</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Frances C. Summers</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>22 East Ninth Street, Frederick, Md. 21701</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>St. Oliver Cemetery Dec. 1, 1992</u>		20c. LOCATION — City or Town, State <u>Frederick, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Robert W. Keeney # M00652</u>				22. NAME AND ADDRESS OF FACILITY <u>Keeney & Basford P.A. Funeral Home</u> <u>106 E. Church St., Fred. Md. 21701</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Pulmonary Edema</u> DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval Between Onset and Death <u>48 hrs.</u>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Coronary Artery disease</u> DUE TO (OR AS A CONSEQUENCE OF):					<u>years</u>
		c. <u>Severe Peripheral Vascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF):					<u>years.</u>
		d. <u>Pseudomonas Septicemia</u> DUE TO (OR AS A CONSEQUENCE OF):					<u>week</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Small bowel obstruction</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u></u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Sara Hultsch-Smith</u>				29c. LICENSE NUMBER <u>D36701</u>		29d. DATE SIGNED (Month, Day, Year) <u>11-28-92</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Dr. Sara Hultsch-Smith M.D. 915 Toll House Rd., Frederick, Md. 21701</u>							
31. DATE FILED (Month, Day, Year) <u>Nov 30 1992</u>		32. REGISTRAR'S SIGNATURE <u>Sara Hultsch-Smith</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37135

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERA VIRGINIA SMITH						2. DATE OF DEATH MONTH DAY YEAR Dec. 18 1992		3. TIME OF DEATH 5:00 pm		
4. SOCIAL SECURITY NUMBER 430-07-8512		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 09 1914		8. BIRTHPLACE (State or Foreign Country) Texas		
9a. FACILITY NAME (If not institution, give street and number) 801 Hambrook Blvd.						9b. CITY, TOWN OR LOCATION OF DEATH Cambridge			9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT										
10a. STATE MD.		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 801 Hambrook Blvd.				10f. ZIP CODE 21613			10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker			16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) William C. Buse						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ara Hare				
19a. INFORMANT'S NAME (Type/Print) Betty S. Boda				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 145 St. Georges DE. 19733						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) E. New Market Cem. 12/22		20c. LOCATION — City or Town, State E. New Market Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge Md. 21613						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of the lung DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD										
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER DS9747		29d. DATE SIGNED (Month, Day, Year) 12/21/92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David G. Oliver MD 2 Aurora St. Cambridge MD 21613										
31. DATE FILED (Month, Day, Year) DEC 22 '92		REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

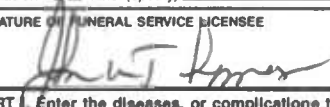
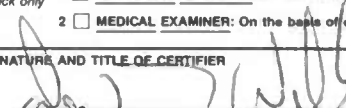
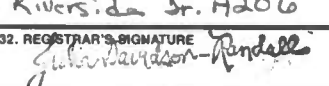
TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37136

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Thelma Neild Sauerhoff				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 19, 1992		3. TIME OF DEATH 2:35 PM	
4. SOCIAL SECURITY NUMBER 577-30-8468		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/27/1902	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 910 Riverside Drive	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? US		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Unknown				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) William H. Neild				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nora Newbury			
19a. INFORMANT'S NAME (Type/Print) John E. Sauerhoff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Farm Rd. New Canaan, Ct. 06840			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Old Trinity Churchyard 12/27 Church Creek, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe disorder, pulmonary embolus, cholelithiasis							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D33796		29d. DATE SIGNED (Month, Day, Year) 12-20-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Walker 560 Riverside Dr. A206 Salisbury, Md. 21801							
31. DATE FILED (Month, Day, Year) DEC 23 '92				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


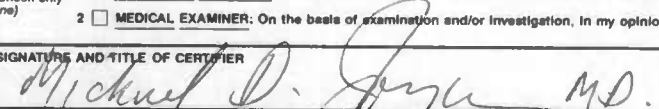
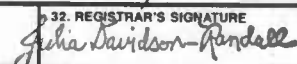
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				92 37137			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Ruth Virginia SIGLEY				12 26 1992				5:00 a M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
232-88-1222		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		79 YRS.		July 6, 1913		West Virginia			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Rt. 3, Box 283				Deer Park				Garrett			
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
MD				Garrett		Deer Park		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
Rt. 3, Box 283				21550				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White					
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12)				College (1-4 or 5+)				Home			
8th				Housewife							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Thomas Jefferson Lindsey				Stella Maude Swiger							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Naomi R. Bartlett				Rt. 1, Box 210, Lumberport, WV 26386							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Preston Memorial Gardens		12/29		Kingwood, West Virginia					
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
				Stewart Funeral Home							
				32 S. Second St., Oakland, MD 21505							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								Minutes			
a. Ventricular Arrhythmia											
DUE TO (OR AS A CONSEQUENCE OF):											
b. Ischemic Heart Disease								Sev. Years			
DUE TO (OR AS A CONSEQUENCE OF):											
c. Arteriosclerotic Cardio-Vascular Disease								Unknown			
DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED?								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				D 05658				December 27, 1992			
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
Herbert H. Leighton, M. D., 502 E. Oak Street, Oakland, Maryland 21550											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
DEC 29 1992											

COLLIER

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILDA BERNITA TYLER				2. DATE OF DEATH MONTH 12 DAY 13 YEAR 92		3. TIME OF DEATH 1645 M	
4. SOCIAL SECURITY NUMBER 217-10-8565		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06 07 1915	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH Cambridge	
9c. COUNTY OF DEATH Dorchester				RESIDENCE OF DECEDENT			
10a. STATE MD.		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1100 School St.				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) & Bernard Rippon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bernita Jones			
19a. INFORMANT'S NAME (Type/Print) Harold W. Tyler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 School St. Cambridge Md. 21613			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Churchyard 12/16		20c. LOCATION — City or Town, State Church Creek Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge Md. 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular disease CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death YRS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12-16-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michael Joyce Dorchester General Hospital Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) DEC 18 '92				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0700

0700

0700

92 37139

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OTIS L. Thomas				2. DATE OF DEATH MONTH December DAY 11 YEAR 1992				3. TIME OF DEATH 2048 M	
4. SOCIAL SECURITY NUMBER 212-66-2188		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-17-1955		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Manokin				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt-1 Box 129-Westover Md.				10f. ZIP CODE 21871		10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer			16b. KIND OF BUSINESS/INDUSTRY Cook		
17. FATHER'S NAME (First, Middle, Last) OTIS Thomas Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) LEONA O. Thomas (WATERS)					
19a. INFORMANT'S NAME (Type/Print) LEONA O. Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt-1 Box 129-Westover Md. 21871					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) John Wesley Cemetery 12-19-92 Manokin Md.				20c. LOCATION — City or Town, State Manokin Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hulthys E. Ward F.D.				22. NAME AND ADDRESS OF FACILITY 103 Hampden Ave. Princess Anne Md. 21853					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severe dilated cardiomyopathy									
a. DUE TO (OR AS A CONSEQUENCE OF):									
b. DUE TO (OR AS A CONSEQUENCE OF): congestive heart failure									
c. DUE TO (OR AS A CONSEQUENCE OF): and pneumonia									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER John R. M. Lee				29c. LICENSE NUMBER D25209		29d. DATE SIGNED (Month, Day, Year) 12/11/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John McLean MD, 106 Milford Street, Salisbury, MD 21801									
31. DATE FILED (Month, Day, Year) DEC 16 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25

92 37140

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ORVILLE Rubin White		2. DATE OF DEATH MONTH December DAY 4 YEAR 1992		3. TIME OF DEATH 1100 M
4. SOCIAL SECURITY NUMBER 219-05-8509-1	5. SEX M	6. AGE (In yrs. last birthday) 74 YRS.	7. DATE OF BIRTH (Month, Day, Year) 5-14-1918	8. BIRTHPLACE (State or Foreign Country) MD
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO
RESIDENCE OF DECEDENT				
10a. STATE md	10b. COUNTY Wicomico	10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER 415-A Patrick Ave		10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 2 Married		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Blk		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary 9-12 College (1-4 or 8+)		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life—do NOT use retired.) Retired		16b. KIND OF BUSINESS/INDUSTRY TRI County Gas Co		
17. FATHER'S NAME (First, Middle, Last) George Thomas White		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Fields White		
19a. INFORMANT'S NAME (Type/Print) Larry White		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 1 Box 356-A Eden Md. 21822		
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD VA Cemetery Harlock Md.		20c. LOCATION — City or Town, State Harlock Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Russell A. Luk		22. NAME AND ADDRESS OF FACILITY Locke Funeral Service 6B 1574 Salisbury Md.		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Death DUE TO (OR AS A CONSEQUENCE OF): b. Aortic Stenosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death MWS MWS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 BOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)		27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER Ana M. Lind MD		29c. LICENSE NUMBER D10688		29d. DATE SIGNED (Month, Day, Year) 12/4/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P.R.M.C. Donald M. Wood Quincy + Locust Sts. Salisbury, Md				
31. DATE FILED (Month, Day, Year) DEC 07 1992		32. REGISTRAR'S SIGNATURE Johia Davidson-Randall		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37141

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alma P Wehr				2. DATE OF DEATH MONTH 12 16 92 YEAR		3. TIME OF DEATH 1:10 A M	
4. SOCIAL SECURITY NUMBER 216-46-1805		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	7. DATE OF BIRTH (Month, Day, Year) 03/29/1904		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton		9c. COUNTY OF DEATH Talbot	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4104 ST. PAUL STREET		10f. ZIP CODE 21218	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE/CAUC.			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER	
17. FATHER'S NAME (First, Middle, Last) COL. ALBANUS PHILLIPS				18. MOTHER'S NAME (First, Middle, Maiden Surname) DAISY ALMA LEWIS			
19a. INFORMANT'S NAME (Type/Print) MR. HARRY WEHR, III (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5631 MORRIS NECK RD., CAMBRIDGE, MD. 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LORRAINE MEM. PK. 12/19		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loreen Farnham Brownell</i>				22. NAME AND ADDRESS OF FACILITY CURRAN FUNERAL HOME 308 HIGH ST., CAMBRIDGE, MD. 21613			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONITIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death HOURS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BEST CA, Dementia Chronic Renal Failure ASCVD, Severe Osteoporosis							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO N/A			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kevin J. O'Keefe MD</i>				29c. LICENSE NUMBER D35259		29d. DATE SIGNED (Month, Day, Year) 12/16/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN J. O'KEEFE MD 606 OUTCHMAN'S LANE, Easton MD 21601							
31. DATE FILED (Month, Day, Year) DEC 18 '92				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on this certificate is to be used for the purpose of death certification only. Page 6 may be retained by the hospital or attending physician.


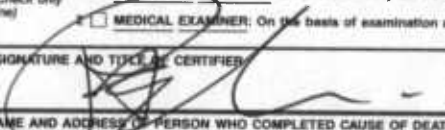
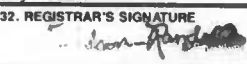
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37142

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Olen Richard WELCH				2. DATE OF DEATH MONTH DAY YEAR December 18, 1992		3. TIME OF DEATH 3:00 A M	
4. SOCIAL SECURITY NUMBER 220-40-1572		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 19, 1941	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Rt. 5, Box 5612		9b. CITY, TOWN OR LOCATION OF DEATH Oakland	
9c. COUNTY OF DEATH Garrett				10a. STATE MD		10b. COUNTY Garrett	
10c. CITY, TOWN OR LOCATION Oakland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Rt. 5, Box 5612	
10f. ZIP CODE 21550				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1962-64				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coal Miner		16b. KIND OF BUSINESS/INDUSTRY Coal Mining	
17. FATHER'S NAME (First, Middle, Last) Lester Roy Welch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Nelle Brown			
19a. INFORMANT'S NAME (Type/Print) Colleen Y. Reckner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 101, Accident, Maryland 21520			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens 12/20		20c. LOCATION — City or Town, State Oakland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial Infarction.</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death Sudden	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Artery Disease.</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D-23979		29d. DATE SIGNED (Month, Day, Year) 12/21/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert Goralski, MD 311 N. Fourth St., Oakland, MD 21550							
31. DATE FILED (Month, Day, Year) DEC 21 1992				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the funeral director or attending physician. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Division of Vital Records, Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE 25

Handwritten notes and diagrams, including a large 'B' and some illegible text.

DEC 18 1980

92 37143

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jo Ann Wagner				2. DATE OF DEATH MONTH DAY YEAR 11 28 1992				3. TIME OF DEATH 5:08 p.m.					
4. SOCIAL SECURITY NUMBER 218-38-6522				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/20/1940		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Olney, Maryland				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 107B North Summit Avenue						10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? American			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY COMSAT					
17. FATHER'S NAME (First, Middle, Last) Unknown						18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown							
19a. INFORMANT'S NAME (Type/Print) J. Willard Main						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23807 Ridge Road, Germantown, Md. 20876							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salem Cemetery 12/1				20c. LOCATION — City or Town, State Germantown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert L. Williams						22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home Damascus, Maryland 20872							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Insulin dependent diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Cardiac arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER John G. Lodmell MD						29c. LICENSE NUMBER D05809			29d. DATE SIGNED (Month, Day, Year) 11-28-92				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN G. LODMELL, MD 2901 Olney Rd. Olney, MD 20832													
31. DATE FILED (Month, Day, Year) NOV 30 1992				32. REGISTRAR'S SIGNATURE John G. Lodmell									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37144

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Paul Thompson Young</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>1</i> YEAR <i>92</i>		3. TIME OF DEATH <i>2:05 P M</i>	
4. SOCIAL SECURITY NUMBER <i>208-10-0408</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>07/07/16</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pa.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>	
9c. COUNTY OF DEATH <i>Montgomery</i>				10a. STATE <i>Md.</i>		10b. COUNTY <i>Montgomery</i>	
10c. CITY, TOWN OR LOCATION <i>Rockville</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>404 S. Horner Lane</i>	
10f. ZIP CODE <i>20850</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> College (1-4 or 5+) <i>Sup. of construction</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Sup. of construction</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Adler Const.</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Paul Young</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Etta Brown</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Lloyd Young</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>20615 Darnestown Rd. Dickerson, Md 20842</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Monocacy</i>		20c. LOCATION — City or Town, State <i>12/3 Beallsville, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William C. Hilt</i>				22. NAME AND ADDRESS OF FACILITY <i>Hilton Funeral Home Barnesville, Md. 20838</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive heart failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <i>Atherosclerotic Cardiovascular disease</i>							
b. <i>Probable pneumonia</i>							
c. <i>Renal insufficiency</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i> <i>Organic brain syndrome</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marly S. Gile M.D.</i>				29c. LICENSE NUMBER <i>D34373</i>		29d. DATE SIGNED (Month, Day, Year) <i>Dec 1, 1992</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Marilyn B. Giles M.D. 19642 Club House Rd #615 Gaithersburg, Md 20879</i>							
31. DATE FILED (Month, Day, Year) <i>DEC 9 1992</i>				32. REGISTRAR'S SIGNATURE <i>John L. Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 sufficiently injury, or other traumatic event, the medical examiner must be notified at once.

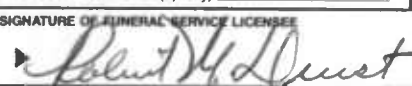


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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CRYSTAL DANETTE ZIMMERMAN				2. DATE OF DEATH MONTH 12- DAY 22 1992 YEAR		3. TIME OF DEATH 9:30 A M		
4. SOCIAL SECURITY NUMBER 214-76-5333		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-28-1953		
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH ANNE ARUNDEL		
RESIDENCE OF DECEDENT								
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION MILLERSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 8398 OAKLAND ROAD				10f. ZIP CODE 21108		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NONE College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A				
17. FATHER'S NAME (First, Middle, Last) RONALD L. ZIMMERMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) SHIRLEY M. RECKART				
19a. INFORMANT'S NAME (Type/Print) MRS. REBECCA L. LEATHERMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8398 OAKWOOD ROAD, MILLERSVILLE, MD. 21108				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRETT MEMORIAL GARDENS 12/24		20c. LOCATION — City or Town, State OAKLAND, MARYLAND				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD. 21550				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY ARREST DUE TO (OR AS A CONSEQUENCE OF):								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):								
c. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 027838		29d. DATE SIGNED (Month, Day, Year) 12/22/92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JOHN SHAVERS 518 CAMP MEADE ROAD, LINTHICUM, MARYLAND 21090								
31. DATE FILED (Month, Day, Year) DEC 23 1992		32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET



1. DECEDENT'S NAME (First, Middle, Last) CLIFFORD ANDERSON, JR.				2. DATE OF DEATH MONTH DAY YEAR DEC. 26 1992		3. TIME OF DEATH 9:35 AM							
4. SOCIAL SECURITY NUMBER 082-20-8494		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 1, 1927		8. BIRTHPLACE (State or Foreign Country) MEDFORD, MA					
9a. FACILITY NAME (If not institution, give street and number) ARCOLA NURSING & REHABILITATION CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING			9c. COUNTY OF DEATH MONTGOMERY						
RESIDENCE OF DECEDENT													
10a. STATE VIRGINIA		10b. COUNTY FAIRFAX		10c. CITY, TOWN OR LOCATION FALLS CHURCH			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
10e. STREET AND NUMBER 2236 MOHEGAN DRIVE #203				10f. ZIP CODE 22046		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII 2/18/45-5/14/46		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER/CONTRACTOR		16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED							
17. FATHER'S NAME (First, Middle, Last) CLIFFORD ANDERSON, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) AUDREY HAYNES									
19a. INFORMANT'S NAME (Type/Print) JOAN M. ANDERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1247 ELDEN ST., #203, HERNDON, VA 22070									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LONG ISLAND NATIONAL CEMETERY		20c. LOCATION — City or Town, State LONG ISLAND, NEW YORK									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Carol F. Groff				22. NAME AND ADDRESS OF FACILITY GREEN FUNERAL HOME, 721 ELDEN ST. HERNDON, VA 22070									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. ALZHEIMERS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death MINUTES FIVE YEAR						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Deborah B. Goldberg						29c. LICENSE NUMBER D17423		29d. DATE SIGNED (Month, Day, Year) 12/26/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEBORAH B. GOLDBERG, MD 8700 GEORGIA AVE., SILVER SPRING, MD 20910													
31. DATE FILED (Month, Day, Year) JAN 5 1993												32. REGISTRAR'S SIGNATURE [Signature]	

SE 31116

Paul F. Smith

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Paul F. Smith

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALFRED BATES				2. DATE OF DEATH MONTH 12 DAY 17 YEAR 1992		3. TIME OF DEATH 5:10 PM	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	7. DATE OF BIRTH (Month, Day, Year) 10-10-1921		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) #1 WEST FRANKLIN STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH na	
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1 W. Franklin Street				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) ocme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 12/31/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/18/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE John Danton-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <div>Ella Margaret Bonolis</div>		2. DATE OF DEATH MONTH DAY YEAR <div>12 29 92</div>		3. TIME OF DEATH <div>1100 P M</div>							
4. SOCIAL SECURITY NUMBER <div>220-12-5786</div>		5. SEX <div>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</div>		6. AGE (In yrs. last birthday) <div>65 YRS.</div>		7. DATE OF BIRTH (Month, Day, Year) <div>7-1-1927</div>		8. BIRTHPLACE (State or Foreign Country) <div>Maryland</div>			
9a. FACILITY NAME (If not institution, give street and number) <div>Francis Scott Key Medical Center</div>				9b. CITY, TOWN OR LOCATION OF DEATH <div>Baltimore City</div>				9c. COUNTY OF DEATH			
10a. STATE <div>Maryland</div>		10b. COUNTY <div>Baltimore</div>		10c. CITY, TOWN OR LOCATION <div>Dundalk</div>		10d. INSIDE CITY LIMITS? <div>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</div>					
10e. STREET AND NUMBER <div>1915 Ewald Avenue</div>				10f. ZIP CODE <div>21222</div>		10g. CITIZEN OF WHAT COUNTRY? <div>U.S.A.</div>					
11. MARITAL STATUS <div>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</div>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <div>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES</div>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <div>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:</div>		14. RACE — American Indian, Black, White, etc. Specify: <div>White</div>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <div>Elementary/Secondary (0-12) College (1-4 or 5+) 8th Grade</div>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <div>Housewife</div>		16b. KIND OF BUSINESS/INDUSTRY <div>Own Home</div>							
17. FATHER'S NAME (First, Middle, Last) <div>Albert McClelland</div>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <div>Margaret Bunger</div>							
19a. INFORMANT'S NAME (Type/Print) <div>Paula M. Dasch</div>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <div>2917 Salisbury Ave., Edgemere, Maryland 21219</div>									
20a. METHOD OF DISPOSITION <div>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</div>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <div>Holly Hill Memorial Cem. 1/2/93</div>		20c. LOCATION — City or Town, State <div>Middle River, Maryland</div>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <div>[Signature]</div>		22. NAME AND ADDRESS OF FACILITY <div>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Dundalk, Maryland 21222</div>									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <div>brain herniation</div> DUE TO (OR AS A CONSEQUENCE OF): b. <div>Stroke</div> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</div>								Approximate Interval Between Onset and Death <div>hours days</div>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <div>Pneumonia, diabetes</div>								24a. WAS AN AUTOPSY PERFORMED? <div>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</div>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <div>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</div>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <div>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</div>		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <div>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</div>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <div>M</div>		28c. INJURY AT WORK? <div>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</div>		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <div>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</div>		29b. SIGNATURE AND TITLE OF CERTIFIER <div>Mark Rich MD</div>		29c. LICENSE NUMBER <div>AJ4147357</div>		29d. DATE SIGNED (Month, Day, Year) <div>12/29/92</div>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <div>Mark Rich - Johns Hopkins 600 N. Wolf Balt, MD</div>											
31. DATE FILED (Month, Day, Year) <div>JAN 25 1993</div>		32. REGISTRAR'S SIGNATURE <div>[Signature]</div>									

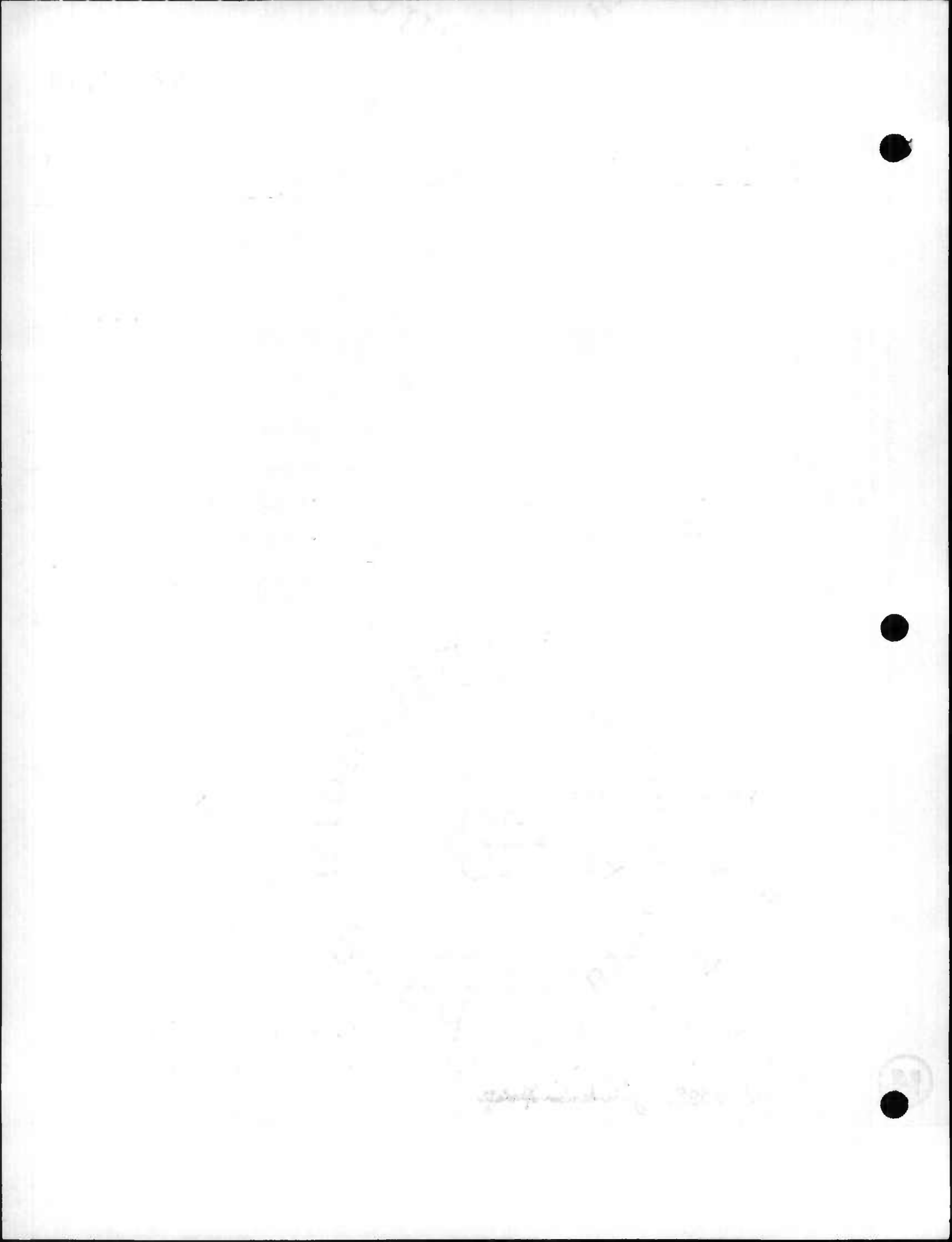
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



92 37149

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>David Earl Brennan</i>				2. DATE OF DEATH MONTH DAY YEAR <i>12 28 92</i>		3. TIME OF DEATH <i>11 55 P M</i>		
4. SOCIAL SECURITY NUMBER <i>217-14-4523</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>68</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>2-24-1924</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT								
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <i>130 Briarwood Road</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th Grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Maintenance</i>		16b. KIND OF BUSINESS/INDUSTRY <i>General Motors Corp.</i>				
17. FATHER'S NAME (First, Middle, Last) <i>Frank Brennan</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Aminta Warnick</i>				
19a. INFORMANT'S NAME (Type/Print) <i>Margaret Ginneman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1 H Sharondale Way Essex, Maryland 21221</i>				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hilltop Service Corp. 12/31/92</i>		20c. LOCATION — City or Town, State <i>Towson, Maryland</i>		20d. DATE <i>12/31/92</i>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. Lash</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222</i>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):								
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD, CAD</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rebecca Elton MD FSKMC Balto MD 21224</i>				29c. LICENSE NUMBER <i>D41955</i>		29d. DATE SIGNED (Month, Day, Year) <i>12.29.92</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rebecca Elton MD FSKMC Balto MD 21224</i>								
31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

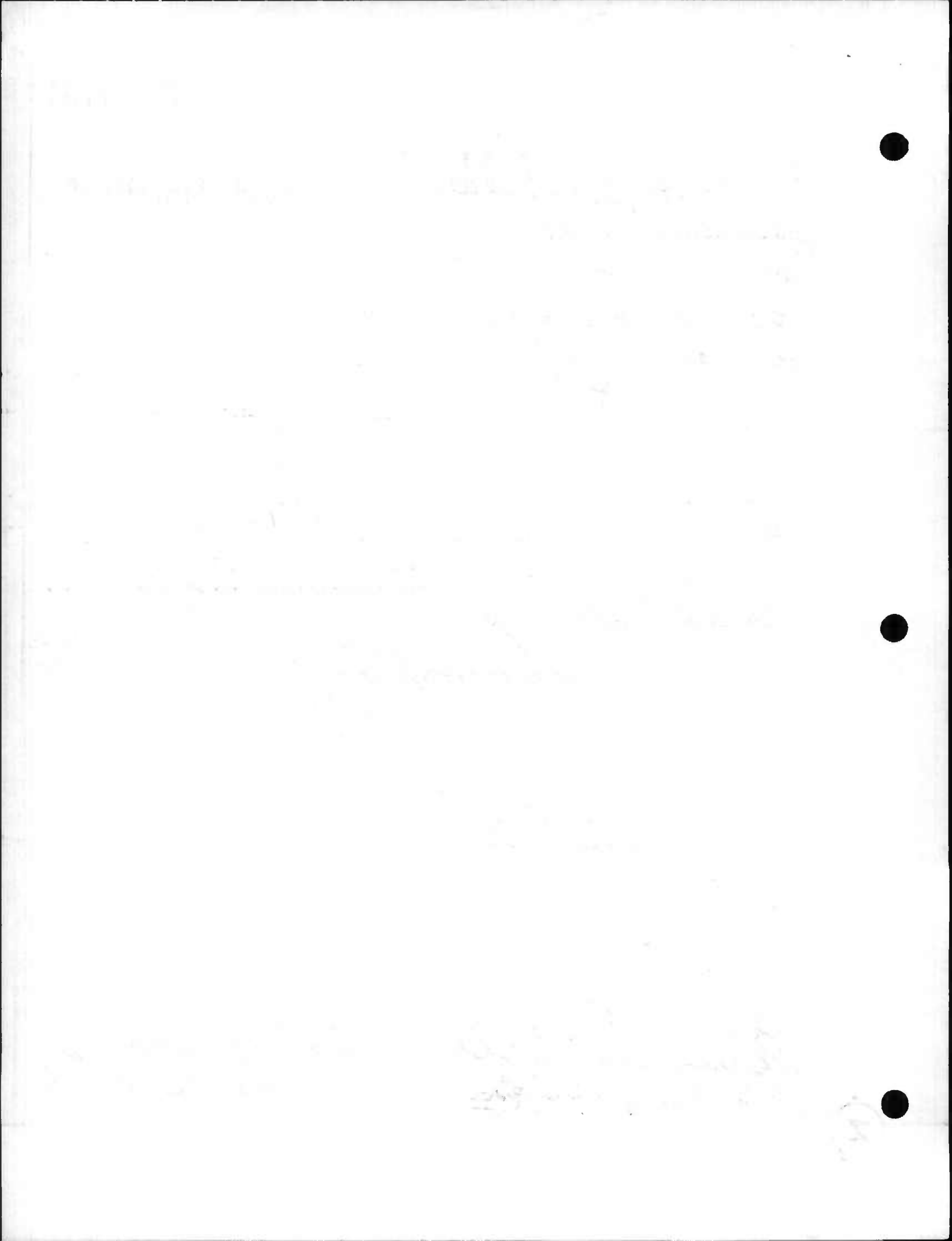
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten signature

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92 37150



LEVI E. BOTTENS

92 37151

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 12-29-92

1. DECEDENT'S NAME (First, Middle, Last) LEVI E. BOTTENS				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92		3. TIME OF DEATH 3:05 PM	
4. SOCIAL SECURITY NUMBER 059-16-0115		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 16, 1903	
8. BIRTHPLACE (State or Foreign Country) ILLINOIS				9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH OLNEY	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MD.		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION OLNEY				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 19205 WILLOW GROVE ROAD	
10f. ZIP CODE 20832				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VICE PRESIDENT				16b. KIND OF BUSINESS/INDUSTRY INSURANCE UNDERWRITERS			
17. FATHER'S NAME (First, Middle, Last) (UNKNOWN) BOTTENS				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) LILLIS M. BOTTENS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS # 10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY			
20c. LOCATION — City or Town, State ALEXANDRIA, VA.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>			
22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 21525 LAYTONSVILLE ROAD LAYTONSVILLE, MD.				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Fractured Right Hip b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 12-23-92			
28b. TIME OF INJURY 7:30 PM				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED Fall				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 19205 Willow Grove Rd.				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Barber MD</i>				29c. LICENSE NUMBER 108546			
29d. DATE SIGNED (Month, Day, Year) 12-29-92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Barber 8218 Wisconsin Ave			
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. SIGNATURE OF REGISTRAR <i>John T. Barber</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY SUSANNAH BUTCHER				2. DATE OF DEATH MONTH DAY YEAR 12-25-92		3. TIME OF DEATH 3:50 P.M.	
4. SOCIAL SECURITY NUMBER 220-32-3479		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/18/06	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. CITY, TOWN OR LOCATION OF DEATH FALLSTON		10. COUNTY OF DEATH HARFORD	
11. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL				12. CITY, TOWN OR LOCATION OF DEATH FALLSTON		13. COUNTY OF DEATH HARFORD	
14a. STATE Maryland		14b. COUNTY Harford		14c. CITY, TOWN OR LOCATION Jarrettsville		14d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15a. STREET AND NUMBER 3748 Jarrettsville Pike				15b. ZIP CODE 21084		15c. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: White	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		22. KIND OF BUSINESS/INDUSTRY Own Home			
23. FATHER'S NAME (First, Middle, Last) James Downs				24. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Kink			
25. INFORMANT'S NAME (Type/Print) Donna Zeigfeld				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3748 Jarrettsville Pike, Jarrettsville, MD 21084			
27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Freedom Cemetery		29. DATE Dec 29, 1992		30. LOCATION — City or Town, State New Freedom, PA 17349	
31. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles T. Bowen				32. NAME AND ADDRESS OF FACILITY J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. Arena - M.D.				29c. LICENSE NUMBER D 43416		29d. DATE SIGNED (Month, Day, Year) 12-29-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Arena - 200 Milton Ave., Fallston, MD 21047							
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Elizabeth Brooks				2. DATE OF DEATH MONTH DAY YEAR December 31, 1992		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-12-4857		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/4/19	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Meridian Health Care Ctr at Brightwood				9b. CITY, TOWN OR LOCATION OF DEATH Brooklandville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Brooklandville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 515 Brightfield Road				10f. ZIP CODE 21022		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY College			
17. FATHER'S NAME (First, Middle, Last) George Edwin Brooks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada May Sorden			
19a. INFORMANT'S NAME (Type/Print) Mrs. Mildred Marshall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Olmstead Road Pikesville, MD 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 1/3/93		20c. LOCATION — City or Town, State Pikesville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>cardiopulmonary arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>severe deforming Rheumatoid Arthritis</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D24569		29d. DATE SIGNED (Month, Day, Year) 1/3/93	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Print) A. SHOROFSKY 660 KENILWORTH TOWSON 21204							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CEPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37154

1. DECEDENT'S NAME (First, Middle, Last) Dorothy A. Brady				2. DATE OF DEATH MONTH DAY YEAR 12 31 92		3. TIME OF DEATH 11:20 P. M.					
4. SOCIAL SECURITY NUMBER 212-01-0740		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/28/1908		8. BIRTHPLACE (State or Foreign Country) Md			
9a. FACILITY NAME (If not institution, give street and number) Meridian Fusting Avenue				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH Baltimore			
10a. STATE Md		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1005 Leeds Avenue				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) clerk		16b. KIND OF BUSINESS/INDUSTRY Insurance							
17. FATHER'S NAME (First, Middle, Last) Ralph A. McCrea				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Hart							
19a. INFORMANT'S NAME (Type/Print) Kathy Cook				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Park Grove Avenue Balto, Md. 21228							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crestlawn		DATE 1/4/93		20c. LOCATION — City or Town, State Marriottsville, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Philip Harris moosso				22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home, Inc 736 Edmondson Avenue 21228							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CAO, breast 2 mets</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>HTN</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D26294		29d. DATE SIGNED (Month, Day, Year) 1/3/93					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1101 Maiden Choice Lane Balto. MD 21229											
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE [Signature]							



Handwritten signature or text, possibly "J. J. ..."

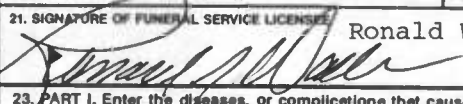
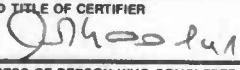
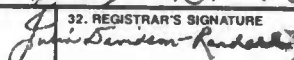
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37155

1. DECEDENT'S NAME (First, Middle, Last) Ralph W Carbaugh				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92				3. TIME OF DEATH 1554 P M							
4. SOCIAL SECURITY NUMBER 219-12-1963				5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04/07/25		8. BIRTHPLACE (State or Foreign Country) unsure					
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital Assoc.						9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown						9c. COUNTY OF DEATH Wash			
RESIDENCE OF DECEDENT															
10a. STATE Md.				10b. COUNTY Washington				10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 11 S. Walnut						10f. ZIP CODE 21740-54				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: American			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9th.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Taxi driver				16b. KIND OF BUSINESS/INDUSTRY Transportation							
17. FATHER'S NAME (First, Middle, Last) Franklin Edgar Carbaugh Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Viola Beckley									
19a. INFORMANT'S NAME (Type/Print) Edith Viola Weaver				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16505 Virginia Ave. C44 Williamsport, Md. 21795											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland State Anatomy Board 12/3/92				20c. LOCATION — City or Town, State Baltimore, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto, MD 21201											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolism DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D21457				29d. DATE SIGNED (Month, Day, Year) 12/30/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABDUL WATTERED MD - 1610 - OAK HILL AVE HAGERSTOWN MD 21742															
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 											

05 07122

JAN 8 1963

92 37156

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John B. Cellitto				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 7:29A	
4. SOCIAL SECURITY NUMBER 213-07-1399		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-12-15	
9a. FACILITY NAME (If not institution, give street and number) Med Bridge Rehab.				9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH Balto	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7 Maya Court				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bridge Builder		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Antonio Cellitto				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Filomena White			
19a. INFORMANT'S NAME (Type/Print) Dolores P. Nocar (Dghtr)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Maya Court, Baltimore, Md. 21220			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cemetery		20c. LOCATION — City or Town, State 1/2/93 Baltimore, Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARCINOMA, PANCREAS DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D23967		29d. DATE SIGNED (Month, Day, Year) 12-31-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Gamboa, Medbridge Rehab., 6600 Ridge Road, Baltimore, Md.							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1915

1915

1915

92-7439-510

92 37157

 ASP
 FOR
 STATE
 REGISTRAR

 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM Francis CUFF				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 1992		3. TIME OF DEATH 5:20 AM	
4. SOCIAL SECURITY NUMBER 189-10-5967		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-12-1907	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY HOSPITAL			
9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH			
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1745 Portship Road				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1931-1935		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bander		15b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corp.			
17. FATHER'S NAME (First, Middle, Last) John Cuff				18. MOTHER'S NAME (First, Middle, Maiden Surname) Not Known			
19a. INFORMANT'S NAME (Type/Print) Alice E. Cuff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1745 Portship Road, Dundalk, Maryland 21222			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 12/31/92		20c. LOCATION — City or Town, State Baltimore, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Dundalk, Maryland 21222		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO INQUIRY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12-29-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLB, JR MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37158

1. DECEDENT'S NAME (First, Middle, Last) GENEVA CORPORA				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 1A M	
4. SOCIAL SECURITY NUMBER 217-28-6662		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-28-1898	
8a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		8c. COUNTY OF DEATH BALTIMORE CITY	
9. RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 740 Poplar Grove Street				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) James Gassaway				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary			
19a. INFORMANT'S NAME (Type/Print) Darlene Clark				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 82 Ambo Circle Chase Md 21220			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) White Rock Cemetery 01/05/93 Sykesville, Md		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leroy Dyett				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 Liberty Heights Ave. Balto. Md. 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → End Stage Renal disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Sher A Hashmi				29c. LICENSE NUMBER D24648		29d. DATE SIGNED (Month, Day, Year) 12-31-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHER A HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0217C 52

Page 10 of 10

CONFIDENTIAL

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March 1964

Item 4, per F.H., G-695, 1/12/93 gn

92 37159

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DANIEL E CARTER				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 31, 1992		3. TIME OF DEATH 2:07 P M	
4. SOCIAL SECURITY NUMBER 212-08-4510		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 25 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-29-67	
8. BIRTHPLACE (State or Foreign Country) BLACK							
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1908 PARK AVENUE				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) CLARENCE CARTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) RUTH HASKINS			
19a. INFORMANT'S NAME (Type/Print) RUTH CARTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 PARK AVE./BALTIMORE, MD 21217			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		DATE		20c. LOCATION — City or Town, State WOODLAWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Symette K. Jones</i>				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Johna Hopkins Hospital - Plastic Surgery</i>				29c. LICENSE NUMBER D39150		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Johna Hopkins Hospital - Plastic Surgery							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
The law requires that the death certificate be executed within 24 hours after death. Pages 5 may be retained by the funeral director or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial or cremation form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37160

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Olivia Campbell		2. DATE OF DEATH MONTH DAY YEAR 12-30-1992		3. TIME OF DEATH 1:20 A. M.	
4. SOCIAL SECURITY NUMBER 216-07-0393	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	7. DATE OF BIRTH (Month, Day, Year) 01-25-1912	8. BIRTHPLACE (State or Foreign Country) Baltimore, Md.	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore City	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4222 Parkside Drive		10f. ZIP CODE 21206	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) Oliver B. Wheeler	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Brickner		19a. INFORMANT'S NAME (Type/Print) Robert J. Campbell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2924 Knoll Acres, Baltimore, Maryland 21234	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cemetery 1/2		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy		22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of colon DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Howard		29c. LICENSE NUMBER D05071	
29d. DATE SIGNED (Month, Day, Year) 12/30/92		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Howard		31. DATE FILED (Month, Day, Year) JAN 5 1993	
32. REGISTRAR'S SIGNATURE Julia Davidson-Hordell		33. REGISTRAR'S SIGNATURE Julia Davidson-Hordell		34. REGISTRAR'S SIGNATURE Julia Davidson-Hordell	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

03/18/60

Dear Mr. [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]

Very truly yours,
[illegible signature]
[illegible name]
[illegible title]

92 37161

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HERMAN HOWARD DUKE				2. DATE OF DEATH MONTH 12 DAY 26 YEAR 92		3. TIME OF DEATH 5:40 P.M.	
4. SOCIAL SECURITY NUMBER 244-28-3819		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-29-1927	
8. BIRTHPLACE (State or Foreign Country) North Carolina							
9a. FACILITY NAME (If not institution, give street and number) Laurel General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1641 B Old Eastern Avenue				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Taxi Driver		16b. KIND OF BUSINESS/INDUSTRY Sun Cab			
17. FATHER'S NAME (First, Middle, Last) Benjamin Van Duke				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Laura Pruitt			
19a. INFORMANT'S NAME (Type/Print) Arlene J. Duke				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8028 Mid Haven Road, Baltimore, MD 21222			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 12/31/92		20c. LOCATION — City or Town, State Towson, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott P. Coomber				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARRHYTHMIA</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul A. DeVore, Deputy Medical Examiner				29c. LICENSE NUMBER 801852		29d. DATE SIGNED (Month, Day, Year) 12/26/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul A. DeVore MD, 4203 Ropesbury Rd Hyattsville MD 20781							
31. DATE (Month, Day, Year) JAN 5 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37162

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Paul Robert DeShesky</u>				2. DATE OF DEATH MONTH <u>12</u> DAY <u>28</u> YEAR <u>92</u>		3. TIME OF DEATH <u>12:50 AM</u>	
4. SOCIAL SECURITY NUMBER <u>171-01-2105</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>92</u> YRS.		7. DATE OF BIRTH MONTH <u>12</u> DAY <u>12</u> YEAR <u>1900</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Eastpoint Nursing Home</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Baltimore City</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore City</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>5329 Selfridge Avenue</u>		10f. ZIP CODE <u>21205</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>8th Grade</u>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Supply Clerk</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Bethlehem Steel Corp.</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Joseph DeShesky</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna Rakar</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Dorothy Nieman</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8040 Kavanagh Road Dundalk, Maryland 21222</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Gardens of Faith Cem. 12/30/92</u>			
20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Chad W. Lohr</u>			
22. NAME AND ADDRESS OF FACILITY <u>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Hepes Zoster of Left Hemispheric</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Prostatic carcinoma</u> b. <u>Prostatic carcinoma</u> c. <u>Prostatic carcinoma</u> d. <u>Prostatic carcinoma</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year) <u>12/28/92</u>				28b. TIME OF INJURY M <u>12:50</u>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>E. Walden M.D.</u>			
29c. LICENSE NUMBER <u>017154</u>				29d. DATE SIGNED (Month, Day, Year) <u>12/28/92</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>E. Walden M.D. 7010 Ritchie Hwy Glen Burnie, Md.</u>							
31. DATE FILED (Month, Day, Year) <u>JAN 5 1993</u>				32. REGISTRAR'S SIGNATURE <u>John Burden</u>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

25 21105

25 21105

92 37163

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) YETTA DONDIS				2. DATE OF DEATH MONTH DAY YEAR Dec. 26 1992		3. TIME OF DEATH 4:31 P M	
4. SOCIAL SECURITY NUMBER 126 14 9564		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 27 1909	
8. BIRTHPLACE (State or Foreign Country) New York							
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 1739 Crestview Drive				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Abraham Altman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Unknown			
19a. INFORMANT'S NAME (Type/Print) Vera Gorrellick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10 a-f			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Park Cemetery 12/29		20c. LOCATION — City or Town, State Paramus New Jersey			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arl., VA 22201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PLEURAL EFFUSION, POSSIBLE LUNG CARCINOMA.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D42518		29d. DATE SIGNED (Month, Day, Year) 12-27-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11251 Lockwood Drive, Silver Spring MD 20901.							
31. DATE FILED (Month, Day, Year) JAN 5 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be kept within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37164

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSE MARIE DEMSKI				2. DATE OF DEATH MONTH DAY YEAR 12 26 1992		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216-24-8263		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-01-1920	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania		9a. FACILITY NAME (If not institution, give street and number) 1701 Rita Road		9b. CITY, TOWN OR LOCATION OF DEATH Dundalk		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1701 Rita Road				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hairdresser		16b. KIND OF BUSINESS/INDUSTRY Self-employed			
17. FATHER'S NAME (First, Middle, Last) Peter Andrzejewicz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Veronica Gustitis			
19a. INFORMANT'S NAME (Type/Print) John J. Demski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Rita Road, Baltimore, MD 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem. 12/29		20c. LOCATION — City or Town, State Baltimore, MD		20d. DATE 12/29	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott P. Gardner				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Melanoma Breast Ca</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D18487		29d. DATE SIGNED (Month, Day, Year) 12/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MYO THANT 9101 FRANKLIN ST. DR, BALTO, MD 21237							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE Julia [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37165

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Willie J. Daniels</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>31</i> YEAR <i>92</i>				3. TIME OF DEATH <i>3:38 P M</i>	
4. SOCIAL SECURITY NUMBER <i>218-36-5199</i>		5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>55</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-6-37</i>		8. BIRTHPLACE (State or Foreign Country) <i>N.C.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Good Samaritan Hosp.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>				9c. COUNTY OF DEATH	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>6856 Sturbridge Dr.</i>				10f. ZIP CODE <i>21235</i>	
10g. CITIZEN OF WHAT COUNTRY?				11. MARITAL STATUS <i>1</i> <input type="checkbox"/> Never Married <i>2</i> <input checked="" type="checkbox"/> Married <i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY				17. FATHER'S NAME (First, Middle, Last) <i>James Daniels</i>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertha Wiggins</i>				19a. INFORMANT'S NAME (Type/Print) <i>James + Bertha Daniels</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Rt 2 Box 403 Grindsland N.C. 27837</i>	
20a. METHOD OF DISPOSITION <i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GREENWOOD CH CHM</i>				20c. LOCATION — City or Town, State <i>GREENWOOD N.C.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>JOSEPH L. RUSS FUNERAL HOME</i> <i>2222 W. NORTH AVE BALTO MD 21216</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>② MCA CVA</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Brain Herniation</i> <i>HTN</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>PVD, CAD</i>	
24a. WAS AN AUTOPSY PERFORMED? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <i>8</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan G. Weiner MD</i>				29c. LICENSE NUMBER <i>034941</i>				29d. DATE SIGNED (Month, Day, Year) <i>12/31/92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SUSAN G. WEINER MD 3001 Loch Raven Blvd Baltimore, Md 21239.</i>				31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>				32. REGISTRAR'S SIGNATURE <i>Julia Swinton-Randall</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37166

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John B. Darr				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 9:00 PM	
4. SOCIAL SECURITY NUMBER 214-16-5660		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 25, 1922	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 5005 Morello Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5005 Morello Road	
10f. ZIP CODE 21214				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parts Manager		16b. KIND OF BUSINESS/INDUSTRY Balto. Gas & Electric			
17. FATHER'S NAME (First, Middle, Last) Herman O. Darr, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Vollnart			
19a. INFORMANT'S NAME (Type/Print) Diana Schoenberger				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8650 Saxon Circle Baltimore 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 1/2/93		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark I. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction							
DUE TO (OR AS A CONSEQUENCE OF): ischemic heart disease							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus hypertension							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER William F. Renner				29c. LICENSE NUMBER DO 9765		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William F. Renner, M.D. 3222 St. Paul Street Baltimore, Md 21218							
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR'S SIGNATURE John Darr					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LYNETTE DRAPER				2. DATE OF DEATH MONTH DECEMBER DAY 29 YEAR 1992				3. TIME OF DEATH 3:45 P M	
4. SOCIAL SECURITY NUMBER 214-72-8645		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 34 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) 11/25/1958				8. BIRTHPLACE (State or Foreign Country) BALTO., MD					
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 615 RADNOR AVENUE				10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Data Entry Clerk				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) EDGAR LEWIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA					
19a. INFORMANT'S NAME (Type/Print) ERIC G. DRAPER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 RADNOR AVE. BALTIMORE, MARYLAND 21212					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK				DATE		20c. LOCATION — City or Town, State RANDALLSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CNS Lymphoma (Central Nervous System) Approximate Interval Between Onset and Death months unknown Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): AIDS (Acquired Immune Deficiency Syndrome) b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO + Refused				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY 12/29/92 (Month, Day, Year)		28b. TIME OF INJURY 1:54 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Hope, MD</i>				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 12/29/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodale</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THEODORE LEONARD DAVIS				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 1992		3. TIME OF DEATH 1 25 P M							
4. SOCIAL SECURITY NUMBER 212-26-5454		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2/20/29		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) St. Josephs Hosp.				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore					
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 3007 Dundalk Ave.				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office		16b. KIND OF BUSINESS/INDUSTRY Auto Plant									
17. FATHER'S NAME (First, Middle, Last) Michael Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Davis									
19a. INFORMANT'S NAME (Type/Print) Virginia S. Davis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1772 Lang Dr., Crofton, Md. 21114									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park		DATE 12-31-92		20c. LOCATION — City or Town, State Howard Co., Md							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083		22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, INC. 2134 Willow Spring Rd., Dundalk, Md. 21222											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure/ARDS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Aspiration Pneumonia Renal Failure Cirrhosis of Liver								Approximate interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Richard Linthicum MD		29c. LICENSE NUMBER D31826		29d. DATE SIGNED (Month, Day, Year) 12-28-92							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard Linthicum MD Saint Joseph Hospital Baltimore Md													
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE [Signature]									

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

671

02. 11. 1941

Handwritten notes and diagrams, including a large circle with internal lines and a smaller circle below it.

Handwritten signature or text at the bottom center.



92 37169

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSEMAN, ROSE Rose Velt Freeman ROSE FREEMAN				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 2:13 P M	
4. SOCIAL SECURITY NUMBER 215 32 0464		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-23-1905	
8. BIRTHPLACE (State or Foreign Country) No Carolina		9a. FACILITY NAME (If not institution, give street and number) THE UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTO. CITY		9c. COUNTY OF DEATH na	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Villa St Michael 4800 Seton Drive				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES no		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Homemaker			
17. FATHER'S NAME (First, Middle, Last) Richard Battle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Ann Battle			
19a. INFORMANT'S NAME (Type/Print) Rae Hillen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2321 Monticello Avenue			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		OATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> 1/4/93				22. NAME AND ADDRESS OF FACILITY StateAnatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Urosepsis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>IDDM</u> <u>Dementia</u>							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marco Castro, MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Marco Castro, MD</i> <i>The Union Memorial Hospital</i>							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>John Benjamin Rader</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37170

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles Nicholas Finn, Sr.</u>				2. DATE OF DEATH MONTH <u>12</u> DAY <u>28</u> YEAR <u>92</u>		3. TIME OF DEATH <u>1929</u> M	
4. SOCIAL SECURITY NUMBER <u>217-18-3747</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>70</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>5-22-1922</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>CHURCH HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Dundalk</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>2985 Cornwall Road</u>				10f. ZIP CODE <u>21222</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th Grade</u> College (14 or 5+) <u>Supervisor</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Supervisor</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Baltimore City Water Dept.</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Maurice Finn</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Adeline Roberto</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Doris T. Finn</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2985 Cornwall Road Dundalk, Maryland 21222</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>St. Stanislaus Cemetery 1/2/93</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>		20d. DATE <u>1/2/93</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Gregory E. Reed</u>				22. NAME AND ADDRESS OF FACILITY <u>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory failure /</u> Due to (or as a consequence of): <u>sepsis syndrome / Multiorgan failure syndrome 18 Days</u> Due to (or as a consequence of): <u>pneumonia /</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive Heart failure, Coronary Artery Disease</u> <u>Atherosclerotic vascular disease</u> <u>Diabetes mellitus</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER <u>Gregory E. Reed M.D.</u>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>KHALID ALTAIB, Church Home Hospital</u>							29c. LICENSE NUMBER <u>D38882</u>
31. DATE FILED (Month, Day, Year) <u>JAN 5 1993</u>							29d. DATE SIGNED (Month, Day, Year) <u>12/28/92</u>
32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92-37171

1. DECEDENT'S NAME (First, Middle, Last) PHYLLIS RAMONA FEARINS		2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 7:03 p.m.	
4. SOCIAL SECURITY NUMBER 213 229 950		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 7 19 29		8. BIRTHPLACE (State or Foreign Country) Maryland		9. COUNTY OF DEATH N/A	
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSP. OF MARYLAND		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9323 WINDSOR MILL ROAD		10f. ZIP CODE 21 244	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Years College (1-4 or 5+) 5 Years	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator/Owner		16b. KIND OF BUSINESS/INDUSTRY Melchor Nursing Home		17. FATHER'S NAME (First, Middle, Last) Winfield Scott Jones	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Dennis		19a. INFORMANT'S NAME (Type/Print) Charles Keith Fearins		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5105 Wards Chapel Road Owings Mills, MD 21117	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Service 1/2/93		20c. LOCATION — City or Town, State Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>GANGRENOUS BOWELS</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. END STAGE RENAL DISEASE 27 to c. POLYCYSTIC KIDNEY DISEASE	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12/31/92	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER NIZAR CHARAFEDDINE, M.D.		29c. LICENSE NUMBER 12/30/92	
29d. DATE SIGNED (Month, Day, Year) 12/30/92		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) NIZAR CHARAFEDDINE, M.D. / GOOD SAMARITAN OF MARYLAND, INC.		31. DATE FILED (Month, Day, Year) JAN 5 1993	
32. REGISTRAR'S SIGNATURE 		33. DATE OF DEATH (Month, Day, Year) 12/31/92		34. TIME OF DEATH 7:03 p.m.	

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92 37172

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALTON C. FORD				2. DATE OF DEATH MONTH 11 DAY 30 YEAR 92		3. TIME OF DEATH 2:45 A. M.	
4. SOCIAL SECURITY NUMBER 215-16-7274		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-16-23	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 601 EAST 35th. STREET		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH				10a. STATE MARYLAND		10b. COUNTY	
10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 601 EAST 35th. STREET	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD WAR II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESMAN				16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) KIMALA J. CONNELLY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 EAST 35th. STREET, BALTO., MD. 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD. VETERIAN CEMETERY 12-31 GARRISON FOREST, MD. 21117			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. G. Ruth				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTO., MD. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cirrhosis of liver DUE TO (OR AS A CONSEQUENCE OF): Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Chronic alcoholism DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 11-30-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7016-510
L.R.B.

92 37173

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM RICHARD GREENE				2. DATE OF DEATH MONTH 12 DAY 10 YEAR 1992		3. TIME OF DEATH 2:46 P M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-26-1943		8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number) 1411 E. FAYETTE STREET.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY.		9c. COUNTY OF DEATH na	
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER No fixed address				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) ocme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir <i>[Signature]</i> 12/31/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Chronic Alcoholism Anemia						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism Anemia						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/11/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37174

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM GRAHAM				2. DATE OF DEATH MONTH 12 DAY 08 YEAR 92		3. TIME OF DEATH 11:00 A.M.	
4. SOCIAL SECURITY NUMBER 213 34 7740		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-15-1938	
9a. FACILITY NAME (If not institution, give street and number) 707 GORSUCH AVE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH na	
10a. STATE Maryland				10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 707 Gorsuch Avenue			
10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) ocme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Locke MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12-09-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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92-7458-510
GMN

92 37175

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Marion Gibula Jr.		2. DATE OF DEATH MONTH DAY YEAR 12 29 1992		3. TIME OF DEATH 1:20 P. M.	
4. SOCIAL SECURITY NUMBER 219-80-6527		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 29 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 8-12-1963		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 815 S. Milton Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH					
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 815 S. Milton Avenue		10f. ZIP CODE 21224	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		16b. KIND OF BUSINESS/INDUSTRY Heating & Air Conditioning	
17. FATHER'S NAME (First, Middle, Last) John M. Gibula, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Marie Price			
19a. INFORMANT'S NAME (Type/Print) Deborah Bannon		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3922 Old North Pt. Road, Dundalk, Maryland 21222			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 1/2/93		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cocoon P. Gaudin		22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contort Gunshot wound of Chest DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12/29/1992		28b. TIME OF INJURY 1:09 PM	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Self-Inflicted Gunshot Wound		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 815 S. Milton Avenue					
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29a. SIGNATURE AND TITLE OF CERTIFIER John A. Locke MD		29b. LICENSE NUMBER O.C.M.E.		29c. DATE SIGNED (Month, Day, Year) 12/30/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Locke, MD 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez			

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 37176

1. DECEDENT'S NAME (First, Middle, Last) Marion Ann Goles						2. DATE OF DEATH MONTH 12 DAY 29 YEAR 1992		3. TIME OF DEATH M		
4. SOCIAL SECURITY NUMBER 212-40-1604		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-3-1943		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 9202 Knottingwood Road						9b. CITY, TOWN OR LOCATION OF DEATH Rosedale		9c. COUNTY OF DEATH Baltimore		
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Rosedale				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 9202 Knottingwood Road				10f. ZIP CODE 21237		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home				
17. FATHER'S NAME (First, Middle, Last) Edward Leo Gentile, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Gertrude Sellers				
19a. INFORMANT'S NAME (Type/Print) Theodore J. Goles, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9202 Knottingwood Road, Rosedale, Maryland 21237						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 1/2/93		20c. LOCATION — City or Town, State Baltimore, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian T. Chisholm				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222						
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMATOUS MENINGITIS DUE TO (OR AS A CONSEQUENCE OF): b. BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate interval between Onset and Death 8 WKS 12 MONTHS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Garry Gordon MD PhD						29c. LICENSE NUMBER D28915		29d. DATE SIGNED (Month, Day, Year) 12/30/92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) GARY GORDON, Johns Hopkins School of Medicine, 725 N. Wolfe St. BAL MD 21205										
31. DATE FILED (Month, Day, Year) JAN 5 1993			32. REGISTRAR'S SIGNATURE John A. ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




2515-60



92 37177

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMIL GATHMANN Emil Gathmann, Jr.				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 120 A	
4. SOCIAL SECURITY NUMBER 212-03-1441		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/29/11	
8. BIRTHPLACE (State or Foreign) New York, N.Y.				9a. FACILITY NAME (If not institution, give street and number) Manor Care Ruxton		9b. CITY, TOWN OR LOCATION OF DEATH Ruxton	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Phoenix				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5 Edgewood Court	
10f. ZIP CODE 21131				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer				16b. KIND OF BUSINESS/INDUSTRY Gathmann Industrial Corp.			
17. FATHER'S NAME (First, Middle, Last) Emill Gathmann, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Isabelle Gary			
19a. INFORMANT'S NAME (Type/Print) Jay N. Gathmann				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3924 Greenpeake Road Madonna, MD.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Cemetery 01/04/93		20c. LOCATION — City or Town, State Baltimore, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD. 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Post-obstructive pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Adenocarcinoma of the lung c. d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dehydration							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MO				29c. LICENSE NUMBER 037016		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth M. Greene, MD 3334 Paper Mill Rd., Phoenix, MD 21131							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/15/1911

11/15/1911

92-6801-510

ASP

92 37178

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALBERT HARRIS				2. DATE OF DEATH MONTH 12 DAY 01 YEAR 1992		3. TIME OF DEATH 8:25 A M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	7. DATE OF BIRTH (Month, Day, Year) 6-6-32	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number) 306 E. NORTH AVE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH na	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 306 E. North Avenue				10f. ZIP CODE 21202		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) ocme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir <i>[Signature]</i> 12/31/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Disease							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) 12-02-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Locke, MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

92 37179

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHNNIE				2. DATE OF DEATH MONTH 11 DAY 30 YEAR 92				3. TIME OF DEATH 8:55 A	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) 3504 CLIFTON AVE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH na	
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3504 Clifton Avenue				10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
19a. INFORMANT'S NAME (Type/Print) OCME				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald Wade, Dir</i> 12/31/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) 11-30-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald G. Wright MD 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) JAN 5 1993									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37180

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED L. HAWKINS				2. DATE OF DEATH MONTH 12 DAY 24 YEAR 92		3. TIME OF DEATH 4:25 am M	
4. SOCIAL SECURITY NUMBER 220-26-6650		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 15, 1916	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH OLNEY	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MD.		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION SANDY SPRING				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1009 ASHLAND DRIVE	
10f. ZIP CODE 20860				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY HOME			
17. FATHER'S NAME (First, Middle, Last) JAMES G. LIVESAY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA DELAPLANE			
19a. INFORMANT'S NAME (Type/Print) D. OLAND HAWKINS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) MT. CARMEL CEMETERY			
20c. DATE 12/28				20d. LOCATION — City or Town, State SUNSHINE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Renal failure Mesenteric vascular occlusion							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure Mesenteric vascular occlusion							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 12/24/92			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Arnold MD</i>				29c. LICENSE NUMBER 005809			
29d. DATE SIGNED (Month, Day, Year) 12 24 92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2901 Olney Sandy Spring Rd. Olney Md 20832			
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. SIGNATURE OF REGISTRAR <i>John S. Arnold</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37181

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Christine Holly				2. DATE OF DEATH MONTH DAY YEAR 12/31/92		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 218-36-2521		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/7/40	
9a. FACILITY NAME (If not institution, give street and number) Liberty Med. Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore,		9c. COUNTY OF DEATH	
10a. STATE Md.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Balto.	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3908 Belle Ave.				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Henry Sanders				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Edmond			
19a. INFORMANT'S NAME (Type/Print) Darrell Holly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 Belle Ave. Balto. Md. Son			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 1/6/93 Balto. Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Wainwright Funeral Home 2700 Edmondson Ave. Balto. Md. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death One year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marshall A. Lume</i>				29c. LICENSE NUMBER D17873		29d. DATE SIGNED (Month, Day, Year) 1/5/93	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OLIVE HERRING

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JUANITA S. HOUSE				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 92		3. TIME OF DEATH 10:15 P.M.	
4. SOCIAL SECURITY NUMBER 212-01-0766		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-20-00	
9a. FACILITY NAME (If not institution, give street and number) BALTIMORE CO. GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION 7600 CLAYS LANE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7600 CLAYS LANE		10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married XX Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES XX NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) SECRETARY		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY BANK			
17. FATHER'S NAME (First, Middle, Last) NELSON E. SNYDER				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORA C. HARRIS			
19a. INFORMANT'S NAME (Type/Print) SARA S. MERIDITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 100, Uwchland, PENNSYLVANIA 19480			
20a. METHOD OF DISPOSITION XX Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY		20c. LOCATION — City or Town, State PIKESVILLE, MD. 21208			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. M. Ruth		22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTO., MD. 21212					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio-Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Fractured Left Hip DUE TO (OR AS A CONSEQUENCE OF): ASCD with Sensibly DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Weakness							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES XX NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: XX Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation XX Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide					
28a. DATE OF INJURY (Month, Day, Year) 12-3-92		28b. TIME OF INJURY P.M.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES XX NO		28d. DESCRIBE HOW INJURY OCCURRED Fallen Room	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Nursing Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Clays Lane Randallstown					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles F. O'Donnell M.D.				29c. LICENSE NUMBER 0383		29d. DATE SIGNED (Month, Day, Year) 12-29-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES F. O'DONNELL M.D., 7505 OSLER DR., TOWSON, MD. 21204							
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR'S SIGNATURE Jana Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37183

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Baby Boy (Keith) Hobbs (B. Hardy, Jr.)				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 8:07 A M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 0 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 2	IF UNDER 24 HRS. HOURS 12 MIN. 28	7. DATE OF BIRTH (Month, Day, Year) 12/28/92	
8. BIRTHPLACE (State or Foreign Country) USA				9. COUNTY OF DEATH Baltimore			
9a. FACILITY NAME (If not Institution, give street and number) Sinai Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2567 Arunah Avenue				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Keith B. Hardy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tamara Hobbs			
19a. INFORMANT'S NAME (Type/Print) Cynthia Hobbs				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2567 Arunah Ave Balto. Md. 21216			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery		DATE 01/05/93		20c. LOCATION — City or Town, State Woodlawn Md. 21207	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leroy O. Dylth				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETH & SON FUNERAL HOME, INC. 4600 Liberty Heights Ave. Balto. Md. 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. Cardiorespiratory Failure DUE TO (OR AS A CONSEQUENCE OF):							
b. Pulmonary Hemorrhage DUE TO (OR AS A CONSEQUENCE OF):							15 hrs
c. Severe Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF):							45 hrs
d. Extreme Prematurity							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Intraventricular Hemorrhage							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Diane B. Saeed				29c. LICENSE NUMBER D43654		29d. DATE SIGNED (Month, Day, Year) 12-30-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Diane B. Saeed MD Sinai Hospital of Baltimore							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10/10/10 10:10:10

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES LORENE HOWARD				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 08:21 AM	
4. SOCIAL SECURITY NUMBER 216-24-1842		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-03-18	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Severn				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 904 South Wieker Road	
10f. ZIP CODE 21144				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Seamstress			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress				16b. KIND OF BUSINESS/INDUSTRY Acme Pad			
17. FATHER'S NAME (First, Middle, Last) Milton Morrison				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cynthia Poole			
19a. INFORMANT'S NAME (Type/Print) Darius Howard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 South Wieker Road, Severn, MD 21144			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery			
20c. LOCATION — City or Town, State Dorsey, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas A. Hardesty			
22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Congestive heart failure Diabetes			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 12/31/92			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Basant K. Khandelwal				29c. LICENSE NUMBER 023624			
29d. DATE SIGNED (Month, Day, Year) 12/31/92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BASANT K. KHADELWAL, M.D./1600 CRAIN HIGHWAY, SW/GLEN BURNIE, MARYLAND 21061			
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE John A. Hardesty			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37185

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH		3. TIME OF DEATH	
Troy Anthony Holmes		MONTH DAY YEAR 12 25 1992		9:21 AM	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)	
213-37-4054		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		YRS. MONTHS DAYS HOURS MIN.	
7a. FACILITY NAME (If not institution, give street and number)		7b. CITY, TOWN OR LOCATION OF DEATH		7c. COUNTY OF DEATH	
26 N. Monroe Street		Baltimore		Maryland	
RESIDENCE OF DECEDENT					
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION	
Maryland				Baltimore	
10d. INSIDE CITY LIMITS?		10e. ZIP CODE		10f. CITIZEN OF WHAT COUNTRY?	
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				U.S.A.	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?	
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc.		Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired!)		16b. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (9-12) College (1-4 or 5 +)		N/A			
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)			
SYIDE ABULLAH		JEAN TAYLOR			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
FRANCES ALOANES		26 N. MONROE ST. BALTIMORE MD.			
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		MD. NATIONAL MEM PK 12999 LAURE MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY			
[Signature]		CARY V. MARSH FUNERAL HOME PA. 270 FREDERICK PASS BALTI MD. 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →					
a. Sudden Infant Death Syndrome					
DUE TO (OR AS A CONSEQUENCE OF):					
b.					
DUE TO (OR AS A CONSEQUENCE OF):					
c.					
DUE TO (OR AS A CONSEQUENCE OF):					
d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one)					
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH					
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)					
28b. TIME OF INJURY					
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one)					
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER					
29c. LICENSE NUMBER					
29d. DATE SIGNED (Month, Day, Year)					
O.C.M.E. 12 25 1992					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					
AM DIXON 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year)					
JAN 5 1993					

92 37186

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOLORES JOHNSON				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 219-26-5984		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-29-36	
9a. FACILITY NAME (If not institution, give street and number) 1228 Winston Ave				9b. CITY, TOWN OR LOCATION OF DEATH Balto. Md		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1228 Winston Avenue				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Carroll Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lauretta Hall			
19a. INFORMANT'S NAME (Type/Print) Robert Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1228 Winston Avenue Balto. Md. 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery		DATE		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVE. BALTO. MD. 21207			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → liver failure DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1 month 1 1/2 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles Padgett</i>				29c. LICENSE NUMBER D15546		29d. DATE SIGNED (Month, Day, Year) 12-30-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Padgett, 5601 Loch Raven Blvd, Baltimore, MD							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7420-003

L.R.B.

92 37187

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BEULAH MAE				2. DATE OF DEATH MONTH DAY YEAR 12 27 1992				3. TIME OF DEATH 8:09 PM	
4. SOCIAL SECURITY NUMBER 228-22-2450		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 08 20 1926	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MD		10b. COUNTY ANNE ARUNDEL COUNTY		10c. CITY, TOWN OR LOCATION GLEN BURNIE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 206 L. SOUTHBRIDGE DRIVE		10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WAITRESS		16b. KIND OF BUSINESS/INDUSTRY K-MART CORPORATION					
17. FATHER'S NAME (First, Middle, Last) GEORGE EDGAR GADDY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY BELL WOODS					
19a. INFORMANT'S NAME (Type/Print) DORIS SIM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7792 EDGEWOOD AVE. PASADENA, MD 21122					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY INC		DATE 12-31		20c. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald G. Wright</i>				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Smoke inhalation</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____									Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Bronchogenic carcinoma right lung</u> <u>Chronic alcoholism</u> <u>Atherosclerotic cardiovascular disease</u>									24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12/27/92		28b. TIME OF INJURY 7:05 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED VICTIM OF HOUSE FIRE.	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 206 L. SOUTH BRIDGE DR.					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/28/1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>James H. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21201

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PAGE 6 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. PAGE 5 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. PAGES 1, 2, 3 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

107



92 37188

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN C. KRAUK				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92				3. TIME OF DEATH 7:12 p.m.		
4. SOCIAL SECURITY NUMBER 216-14-4239		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		
7. DATE OF BIRTH (Month, Day, Year) 9-17-11				8. BIRTHPLACE (State or Foreign Country) MD.						
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN-HOMEWOOD				9b. CITY, TOWN OR LOCATION OF DEATH BALTO. CITY				9c. COUNTY OF DEATH		
10a. STATE MD.			10b. COUNTY			10c. CITY, TOWN OR LOCATION BALTO. CITY			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6000 BELLONA AVE. BALTO. MD.				10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPER				16b. KIND OF BUSINESS/INDUSTRY BOOKKEEPING		
17. FATHER'S NAME (First, Middle, Last) HENRY ELLIGSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA BAUER						
19a. INFORMANT'S NAME (Type/Print) DOROTHY CAMPBELL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 BELLONA AVE. LUTHERVILLE, MD. 21093						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM. 1/4				20c. LOCATION — City or Town, State BALTO.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William R. Davis III</i>				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR Dis DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. DUE TO (OR AS A CONSEQUENCE OF): _____ c. DUE TO (OR AS A CONSEQUENCE OF): _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death year		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				26a. DATE OF INJURY (Month, Day, Year)				26b. TIME OF INJURY M _____		
26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26d. DESCRIBE HOW INJURY OCCURRED						
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
27a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								27b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		
27c. LICENSE NUMBER D-12041				27d. DATE SIGNED (Month, Day, Year) 4 Jan 93						
28. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIE LEAVEY M.D. 7600 OSLER DR. SUITE 315 TOWSON, MD. 21204.										
29. DATE FILED (Month, Day, Year) JAN 5 1993				30. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

80,57 50

92-7495-510
L.R.B.

92 37189

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN WESLEY KELLY, III				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 1992		3. TIME OF DEATH 4:12 P.M.					
4. SOCIAL SECURITY NUMBER 220-74-6182		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 23 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-28-1969		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) ARGONNE DRIVE & HILLEN ROAD				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY.			9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT											
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 2014 EAST 31st street				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) JOHN WESLEY KELLY JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) VANASSA V. JONES							
19a. INFORMANT'S NAME (Type/Print) VANASSA V. JONES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 MANCHESTER AVE. BALTO. MD 21215							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul C. M. E. Cem		DATE 1993		20c. LOCATION — City or Town, State Walterboro, S. C.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis B. Scott</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue							
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) PUBLIC STREET.								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year) 12/31/92		28b. TIME OF INJURY 4:03 P.M.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED PASSENGER IN AUTO THAT STRUCK FIXED OBJECT		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golle Jr.</i>			29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 01/01/1993			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLLE JR. M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) JAN 5 1993			32. REGISTRAR'S SIGNATURE <i>Mario F. Golle Jr.</i>								

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

FOR THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37190

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CAROLE MAUREEN ANN KIRCHNER				2. DATE OF DEATH MONTH DAY YEAR 12 29 1992		3. TIME OF DEATH 10:45 pm	
4. SOCIAL SECURITY NUMBER 212-62-5663		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06 20 1939	
8. BIRTHPLACE (State or Foreign Country) ENGLAND				9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 308 DELAWARE AVE.	
10f. ZIP CODE 21060				10g. CITIZEN OF WHAT COUNTRY? ENGLAND		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) NONE			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CASHIER				16b. KIND OF BUSINESS/INDUSTRY MANUFACTURER'S CLOTHING OUTLET			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN CLEWLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCES UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) CHARLES J. KIRCHNER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 DELAWARE AVE. GLEN BURNIE, MD 21060			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 1-2-92			
20c. LOCATION — City or Town, State GLEN BURNIE, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. George Hopkins			
22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Shock DUE TO (OR AS A CONSEQUENCE OF): a. pneumonia with ARDS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
24. Approximate Interval Between Onset and Death 1 day 22 days				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Scleroderma Pulmonary interstitial fibrosis			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER RESIDENT PHYSICIAN RONALDO MAYUEA 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 12/29/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RONALDO MAYUEA 5601 LOCHRAVEN BALTIMORE MD 21239				31. DATE FILED (Month, Day, Year) JAN 5 1993			
32. REGISTRAR'S SIGNATURE [Signature]							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37191

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Cynthia Noel LeCompte</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>29</i> YEAR <i>92</i>		3. TIME OF DEATH <i>12:40 P M</i>	
4. SOCIAL SECURITY NUMBER <i>N/A</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		5. AGE (In yrs. last birthday) YRS. MONTHS <i>4</i> DAYS <i>9</i> HOURS MIN.		7. DATE OF BIRTH <i>12-25-1992</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION	
10d. INSIDE CITY LIMITS? 1 YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>2025 Jasmine Road</i>		10f. ZIP CODE <i>21222</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>Dependent</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			
16b. KIND OF BUSINESS/INDUSTRY				17. FATHER'S NAME (First, Middle, Last) <i>Edward Lawrence LeCompte</i>			
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Patricia Ann Rolek</i>				19a. INFORMANT'S NAME (Type/Print) <i>Mr. & Mrs. Edward L. LeCompte</i>			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2025 Jasmine Road, Dundalk, Maryland 21222</i>				20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery 12/31/92</i>				20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott P. Gaudin</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. PREMATUREITY - 24 WEEK GESTATION</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>LIFE</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i>1</i> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald L. Gutberlet, M.D.</i>		29c. LICENSE NUMBER <i>D03585</i>		29d. DATE SIGNED (Month, Day, Year) <i>12/29/92</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>RONALD L. GUTBERLET, M.D. - MERCY MED CNTA</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>		32. REGISTRAR'S SIGNATURE <i>John L. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18.4.52

18.4.52

18.4.52

18.4.52

92 37192

Item 20c, per F.H., G-696, 2/12/93 gn

FOR
STATE
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES S. LECLAIR				2. DATE OF DEATH MONTH 12 DAY 19 YEAR 92		3. TIME OF DEATH 3:49 P.M.	
4. SOCIAL SECURITY NUMBER 034-05-0910		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-03-07	
8. BIRTHPLACE (State or Foreign Country) BOSTON, MASS				9a. FACILITY NAME (If not Institution, give street and number) THE WESTWOOD		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MD		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION BETHESDA				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5101 RIDGEFIELD RD	
10f. ZIP CODE 20816				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOUSEWIFE			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) BERNARD T. DEEHAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY MCALOON			
19a. INFORMANT'S NAME (Type/Print) CAROL BERGIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9613 EAGLE RIDGE DR BETHESDA, MD 20817			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CANARY CEMETERY			
20c. LOCATION — City or Town, State NEWTON, MASS				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Douglas A. Carson #M00690			
22. NAME AND ADDRESS OF FACILITY F.J. Joyce and Sons Funeral Home 02154 245 Main Street, Waltham, Massachusetts				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE b. CHRONIC RENAL INSUFFICIENCY c. PERIPHERAL VASCULAR DISEASE d. PERIPHERAL VASCULAR DISEASE			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 12/19/92			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Peter G. Hann MD				29c. LICENSE NUMBER D32053			
29d. DATE SIGNED (Month, Day, Year) 12/19/92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER G. HANN MD 5454 WSC AVE CHEVY CHASE MD 20815			
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or name.

Handwritten number 14 inside a circle.

Handwritten text at the bottom of the page.

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37193

1. DECEDENT'S NAME (First, Middle, Last) MCKINLEY ERNEST LEWIS				2. DATE OF DEATH MONTH DAY YEAR December 22, 1992		3. TIME OF DEATH 5:35 P M			
4. SOCIAL SECURITY NUMBER 234-62-4743		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 11, 1942		8. BIRTHPLACE (State or Foreign Country) Keyser, WV	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland			9c. COUNTY OF DEATH Allegany		
10a. STATE WV		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Keyser			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 580 Carskadon Road				10f. ZIP CODE 26726		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Employee		16b. KIND OF BUSINESS/INDUSTRY Glass Manufacturing					
17. FATHER'S NAME (First, Middle, Last) McKinley Roosevelt Lewis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Frances Miller					
19a. INFORMANT'S NAME (Type/Print) Patricia A. Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 580 Carskadon Road Keyser, WV 26726					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Potomac Memorial Gardens 12/26/92		20c. LOCATION — City or Town, State Keyser, WV					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brian L. Smith</i>				22. NAME AND ADDRESS OF FACILITY 85 South Main Street Rotruck-Smith Funeral Home Keyser, WV 26726					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Colon carcinomatosis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death <i>1 year</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>F. Miltenberger</i>				29c. LICENSE NUMBER D 14393		29d. DATE SIGNED (Month, Day, Year) <i>90 Dec 92</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Name) Dr. F. Miltenberger, Johnson Heights Medical Bldg., Cumberland, MD 21502									
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR <i>John A. ...</i>							

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also provides a brief overview of the methods used in the study.

2. The second part of the report is a detailed description of the experimental procedures. It includes a description of the apparatus used, the methods of data collection, and the methods of data analysis. It also includes a description of the results of the experiments.

3. The third part of the report is a discussion of the results of the experiments. It discusses the significance of the results and compares them with the results of other studies. It also discusses the limitations of the study and suggests directions for future research.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and provides a final statement on the importance of the research.

92 37194

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Luiz Fernandes Lopes				2. DATE OF DEATH MONTH 12 - DAY 31 - YEAR 92		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 191-24-9861		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-9-29	
8. BIRTHPLACE (State or Foreign Country) Portugal				9. COUNTY OF DEATH Baltimore			
9a. FACILITY NAME (If not institution, give street and number) 1209 Rustic Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Rosedale			
10a. STATE MD				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Rosedale	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1209 Rustic Ave.			
10f. ZIP CODE 21237				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: PORTUGUESE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) /		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Afonso Lopes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fernanda Queliha			
19a. INFORMANT'S NAME (Type/Print) Alice Steck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 MISTY MEADOW CT, BALTO, MD 21221			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith		DATE		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Denis S Kelly				22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death ± 6 MOS.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY M		27c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27d. DESCRIBE HOW INJURY OCCURRED		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Wilhelmina C. Pagliuca, M.D.				29c. LICENSE NUMBER D15021		29d. DATE SIGNED (Month, Day, Year) 1/1/93	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8552 PHILADELPHIA RD, BALTIMORE, MD 21237							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21202

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2011-12-31



92-7494-510
CIP

92 37195

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EZEKIEL LITTLE JR.				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 1992		3. TIME OF DEATH 5:08 PM	
4. SOCIAL SECURITY NUMBER 244-20-1645		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-02-26	
8. BIRTHPLACE (State or Foreign Country) Patoga N.C.				9a. FACILITY NAME (If not institution, give street and number) 1500 EAST FEDERAL STREET		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH				10a. STATE MD		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1627 Oliver Street (East)	
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Ezekiel Little				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lee			
19a. INFORMANT'S NAME (Type/Print) Audrey B. Little				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1627 E. Oliver Street Balto. Md. 21213			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. 01/6/93		20c. LOCATION — City or Town, State Owings Mills, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leroy O. Dyett				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVE. BALTO. MD 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ON STREET		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 01/01/1992	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. F. G. G. G.				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 01/01/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARLO F. GOLLE, JR MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 10 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37196

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William B Moore				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 1200 M	
4. SOCIAL SECURITY NUMBER 414181531		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-16-1917	
8. BIRTHPLACE (State or Foreign Country) ALABAMA							
9a. FACILITY NAME (If not institution, give street and number) Sinai Hosp.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER			
10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY? U.S.A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Joseph Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorthea Moore			
19a. INFORMANT'S NAME (Type/Print) ALICE V. MOORE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6505 ARMSTRONG AVE BALTO MD 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND NAT CEM		20c. LOCATION — City or Town, State LAUREL P.G.C. MD		20d. DATE 12-30-92	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ				22. NAME AND ADDRESS OF FACILITY 2222 W. NORTH AVE BALTIMORE MD 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. respiratory failure DUE TO (OR AS A CONSEQUENCE OF):							
b. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12-30-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alderson Kimura Sinai Hosp. of Baltimore							
31. DATE FILED (Month, Day, Year) JAN - 5 1993							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-2001

ITEMS: 23 PART I, 27 PER MEO G-695 1/6/93 reb

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Varitta McCullough				2. DATE OF DEATH MONTH DAY YEAR 12 18 1992		3. TIME OF DEATH 2:02 P. M.	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 38 YRS.	7. DATE OF BIRTH (Month, Day, Year) 9-28-1954		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) Clarysville Inn- Room 12				9b. CITY, TOWN OR LOCATION OF DEATH Frostburg		9c. COUNTY OF DEATH Allegany	
10a. STATE Maryland		10b. COUNTY Allegany County		10c. CITY, TOWN OR LOCATION Frostburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Room 12 Clarysville Inn				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) ocme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir <i>Ronald Wade</i> 12/31/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto. MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Inn					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golog, Jr.</i>					
29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/20/1992					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLOG, JR. 11 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR'S SIGNATURE <i>John Benison-Rudolph</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37198

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES EDWARD MULLEN				2. DATE OF DEATH MONTH DAY YEAR 12 30 92		3. TIME OF DEATH 8:05 P M	
4. SOCIAL SECURITY NUMBER 219 07 7823		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/26/20	
8a. FACILITY NAME (If not institution, give street and number) VA MEDICAL CENTER, FORT HOWARD				9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8208 MILLERS ISLAND ROAD			
10f. ZIP CODE 21219				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 YRS College (1-4 or 5+) FABRICATION DEPT.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STEEL CO.		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) EDWARD MULLEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA WALSMITH			
19a. INFORMANT'S NAME (Type/Print) CLINICAL RECORDS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9600 NORTH POINT ROAD, FT HOWARD, MD 21052			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 1-1-93 Balto., Md.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083				21b. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, Md. 21222			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (First disease or condition resulting in death) → CARDIO PULMONARY FAILURE DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. BRAIN METASTATIC LESION DUE TO (OR AS A CONSEQUENCE OF):							
c. MELANOMA LUNG DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Wen-Shyang Wu, M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12-31-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WEN-SHYANG WU, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE Julia Anderson-Henderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37199

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Horst Niebuhr</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>29</i> YEAR <i>92</i>				3. TIME OF DEATH <i>M</i>	
4. SOCIAL SECURITY NUMBER <i>213-34-0477</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>57</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	
7. DATE OF BIRTH (Month, Day, Year) <i>6-9-1935</i>				8. BIRTHPLACE (State or Foreign Country) <i>Germany</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>				9c. COUNTY OF DEATH	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>8117 Cornwall Road</i>				10f. ZIP CODE <i>21222</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Shipping</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Consolidated Freight</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Karl Niebuhr</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Frieda Kroeger</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Gerda Niebuhr</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8117 Cornwall Road Dundalk, Maryland 21222</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hilltop Service Corp. 12/31/92</i>				20c. LOCATION — City or Town, State <i>Towson, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gregory E. Reed</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave., Dundalk, Maryland 21222</i>					
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Metastatic Renal Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d.</i>								Approximate Interval Between Onset and Death <i>6 years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pleural effusions</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margaret M. Duval MD</i>				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <i>12/29/92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Tower 110 Doctors Office, Johns Hopkins Hospital, Baltimore, MD 21205</i>									
31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37200

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jessie Adelaide Newman</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>31</i> YEAR <i>92</i>		3. TIME OF DEATH <i>1750</i> <i>P</i>	
4. SOCIAL SECURITY NUMBER <i>218-16-1406</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>80</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>10-4-1912</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>PENINSULA REGIONAL MEDICAL CENTER</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>SALISBURY</i>		9c. COUNTY OF DEATH <i>WICOMICO</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>8108 Dundalk Avenue</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th Grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Clarence P. Parsons</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lillian A.</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Patricia Friedly</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Rt 1 Box 96 Mardella Springs, Maryland 21837</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Moreland Memorial Park 1/4/93</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph E. Reed</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Dundalk, Maryland 21222</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>CHF</i> b. <i>Arteriosclerosis</i> c. <i>Diabetes</i> d. <i>Obesity</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William H. Robins</i>				29c. LICENSE NUMBER <i>029349</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/1/93</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William H. Robins M.D. 1104 Heathway Dr. Salisbury, Md.</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>				32. REGISTRAR'S SIGNATURE <i>Jessie Adelaide Newman</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37201

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Oldham				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 92				3. TIME OF DEATH 0558 M	
4. SOCIAL SECURITY NUMBER 402-72-5105		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/18/52		8. BIRTHPLACE (State or Foreign Country) KENTUCKY	
9a. FACILITY NAME (If not institution, give street and number) 54 LAKE Shore Dr.				9b. CITY, TOWN OR LOCATION OF DEATH PASADENA				9c. COUNTY OF DEATH AA	
10a. STATE MD		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 54 LAKE SHORE DRIVE				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1970-1976		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		College (1-4 or 8+) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION		16b. KIND OF BUSINESS/INDUSTRY RATRIE, ROBBINS & SCHWEIZER			
17. FATHER'S NAME (First, Middle, Last) SAMUEL EDWARD OLDHAM				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLIA MAE BOLIN					
19a. INFORMANT'S NAME (Type/Print) RICHARD M. JEFFREY, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 D FAYWOOD CT. GLEN BURNIE, MD 21060					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		DATE 1993		20c. LOCATION — City or Town, State ELKRIDGE MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Henry Hopkins</i>				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gastrointestinal Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Cirrhosis Liver DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD Deputy</i>		29c. LICENSE NUMBER DO6054		29d. DATE SIGNED (Month, Day, Year) 12/28/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD PO Box 99 20711									
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR'S SIGNATURE <i>John W. ...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IF ITEM 28 IS MARKED, OR ITEM 23 SHOWS ANY INJURY, OR OTHER TRAUMATIC EVENT, THE MEDICAL EXAMINER MUST BE NOTIFIED AT ONCE.

10550 08



92-7161-510

blh

ITEMS: 23 PART I, 27, 28a, b, c, d, e, f per MEO G-695 1/6/93 reb

92 37202

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Perry				2. DATE OF DEATH MONTH DAY YEAR 12 15 1992		3. TIME OF DEATH 5:45 A M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 33 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11-5-1959	
8a. FACILITY NAME (If not institution, give street and number) War Memorial Plaza- 100 blk N. Gay Street				8b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8c. COUNTY OF DEATH na	
10a. STATE Maryland		10b. COUNTY na		10c. CITY, TOWN OR LOCATION 202 N. Fulton Avenue Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 202 N. Fulton Avenue				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) ocme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir <i>Ronald Wade</i> 12/31/92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Blato. MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC AND ALCOHOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND: 12/15/92		28b. TIME OF INJURY FOUND 5:40 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) UNKNOWN		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT INGESTED DRUGS AND ALCOHOL					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) UNKNOWN		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) UNKNOWN					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12 15 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37203

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Nina A. Palmer</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>31</i> YEAR <i>92</i>		3. TIME OF DEATH <i>10:24 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>213-70-3848</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-7-1910</i>	
8. BIRTHPLACE (State or Foreign Country) <i>W. Virginia</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key M.C.</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>Harford</i>				10a. STATE <i>Maryland</i>			
10b. COUNTY <i>Harford</i>				10c. CITY, TOWN OR LOCATION <i>3203 E. BAYVIEW STREET</i>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>3203 E. BAYVIEW STREET</i>			
10f. ZIP CODE <i>21224</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> College (1-4 or 5+) <i>—</i>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		17. KIND OF BUSINESS/INDUSTRY <i>None</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John McGhee</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Laura Newberry</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Pastor F. J. Palmer</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>216 Marshall Dr. Forest Hill Md. 21050</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>DALLMAN CEM. 1-4 Baltimore Md.</i>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles Banning</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph A. Zannino Jr. F.H. 363 S. Conkling St. Baltimore Md.</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Anterior myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Coronary Artery disease</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>pericardial tamponade</i> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward P. Shapiro</i>				29c. LICENSE NUMBER <i>D19670</i>		29d. DATE SIGNED (Month, Day, Year) <i>12/31/92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Edward P. Shapiro (Baltimore Avenue Baltimore Md.)</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37204

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PETER Paul POGGI				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 9 08/A M	
4. SOCIAL SECURITY NUMBER 219 18 2401		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/27/25	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 4607 Anntana Ave.		10f. ZIP CODE 21206	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 Yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Estimator		16b. KIND OF BUSINESS/INDUSTRY Baltimore City	
17. FATHER'S NAME (First, Middle, Last) Antonio Poggi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Magdalena DelGrosso			
19a. INFORMANT'S NAME (Type/Print) Rose Poggi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4607 Anntana Ave., Baltimore, Md. 21206			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 1-4-93		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Roy H. Cather				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colon Cancer with Metastatic Disease to the Liver							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Inpatient/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Scott Rifkin				29c. LICENSE NUMBER D34145		29d. DATE SIGNED (Month, Day, Year) 12/4/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Scott Rifkin, M.D., 21 Crossroads Drive Suite #330 Owings Mills, Md. 21117							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE John Davidson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director must complete and sign the certificate and completely fill in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7443-510

GMN

ITEMS: 23 PART I, 27 PER MEO G-695 1/14/93 reb

92 37205

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Donnie Pulliam				2. DATE OF DEATH MONTH DAY YEAR 12 29 1992		3. TIME OF DEATH 9:05 A.M.	
4. SOCIAL SECURITY NUMBER 499-76-5890		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/18/1961	
8. BIRTHPLACE (State or Foreign Country) MEXICO				9a. FACILITY NAME (If not institution, give street and number) 2 S. Woodington Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2 S. WOODINGTON ROAD	
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Burnice F. Pulliam				18. MOTHER'S NAME (First, Middle, Maiden Surname) Olene D. Walker			
19a. INFORMANT'S NAME (Type/Print) Burnice F. Pulliam				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7211 Sawmill Branch Rd Baltimore, MD 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. LOCATION — City or Town, State RANDALLSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DILATED CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Baron Wark MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/29/1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Baron Wark MD</i> 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37206

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY ESTELLE PORTER						2. DATE OF DEATH MONTH DAY YEAR 12 30 1992		3. TIME OF DEATH 5:35a			
4. SOCIAL SECURITY NUMBER 217-50-7506		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06 15 1915		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) St Agnes Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH			
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CATONSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 715 MAIDEN CHOICE LANE CR204				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NONE		16b. KIND OF BUSINESS/INDUSTRY OWN HOME							
17. FATHER'S NAME (First, Middle, Last) WALLACE SHEARER						18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN					
19a. INFORMANT'S NAME (Type/Print) QUINTIN K. PORTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 BRANDYWINE AVE. SEVERNA PARK, MD 21146							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 1-2-93		20c. LOCATION — City or Town, State GLEN BURNIE, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Hopkins</i>				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary artery disease</u> <u>CVA</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Javier Calderon, M.D.</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/30/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Javier Calderon, 900 Caton Ave., Balto, MD 21229											
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>Juan Davidson-Rodriguez</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37207

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Harriet Clarke Mc Daniel</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>29</i> YEAR <i>92</i>		3. TIME OF DEATH <i>3:30 A.</i> M	
4. SOCIAL SECURITY NUMBER <i>218-18-3732</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>11 17 14</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>412 South Eaton Street</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH	
10a. STATE <i>Md.</i>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>412 S. Eaton St.</i>		10f. ZIP CODE <i>21224</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Salesperson</i>				17. KIND OF BUSINESS/INDUSTRY <i>Department Store</i>		18. FATHER'S NAME (First, Middle, Last) <i>Clarke</i>	
19. MOTHER'S NAME (First, Middle, Maiden Surname)				19a. INFORMANT'S NAME (Type/Print) <i>Robert Mc Daniel</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>412 S. Eaton St. Balto., Md. 21224</i>	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Mount Crematory 12-31-92</i>		20c. LOCATION — City or Town, State <i>Balto., Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles S. Zeiler</i>				22. NAME AND ADDRESS OF FACILITY <i>Charles S. Zeiler & Son Inc. 901 S. Conkling St.</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Sudden death of uncertain etiology</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>b. Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. Cerebrovascular disease.</i> DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Harry Kaplan</i>				29b. LICENSE NUMBER <i>D40371</i>		29c. DATE SIGNED (Month, Day, Year) <i>12/31/92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr Harry Kaplan 4940 Eastern Avenue Baltimore, Md. 21236.</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>				32. REGISTRAR'S SIGNATURE <i>Gail Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, for item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(2)

D.H.C.

Avenue

92 37208

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN QUINN Helen E. Quinn				2. DATE OF DEATH MONTH DAY YEAR DEC. 31, 1992		3. TIME OF DEATH 4:35 A.	
4. SOCIAL SECURITY NUMBER 220-46-4384		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 17, 1900	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY - - - -		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4300 Arabia Ave.			
10f. ZIP CODE 21214				10g. CITIZEN OF WHAT COUNTRY? U. S. A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Louis Quinn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Dixon			
19a. INFORMANT'S NAME (Type/Print) Margaret Cody (Friend)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2387 Danforth Rd., Spring Hill, Florida 34608			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. LOCATION — City or Town, State 1/8/93 Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute CVA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>a. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> </div> </div>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 008358		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GRACIA V. PATRICIO							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37209

1. DECEDENT'S NAME (First, Middle, Last) Arget Richards				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92		3. TIME OF DEATH 9:20 p.m.							
4. SOCIAL SECURITY NUMBER 097-28-9555		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) APR 9, 1913		8. BIRTHPLACE (State or Foreign Country) England					
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Montgomery			9c. COUNTY OF DEATH Olney						
RESIDENCE OF DECEDENT													
10a. STATE Virginia		10b. COUNTY Loudoun		10c. CITY, TOWN OR LOCATION Leesburg			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 203 Stratford Place, S.W.				10f. ZIP CODE 22075		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Agriculturist			16b. KIND OF BUSINESS/INDUSTRY Agriculture							
17. FATHER'S NAME (First, Middle, Last) Samuel Richards				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Brown									
19a. INFORMANT'S NAME (Type/Print) Barbara J. Richards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Stratford Place SW Leesburg, VA 22075									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery		DATE 1/2/93		20c. LOCATION — City or Town, State Leesburg, Virginia							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barry L. Zotman</i>				22. NAME AND ADDRESS OF FACILITY Colonial Funeral Home of Leesburg, Inc. 201 Edwards Ferry RD, N.E. Leesburg, VA 22075									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Paulsen</i>		29c. LICENSE NUMBER 208546		29d. DATE SIGNED (Month, Day, Year) 12-29-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Paulsen 2218 Wisconsin Ave Bethesda Md													
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>John Paulsen</i>									

92 37210

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Bernard Reed</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>30</i> YEAR <i>92</i>		3. TIME OF DEATH <i>11 50 P M</i>	
4. SOCIAL SECURITY NUMBER <i>218-09-8941</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>4/8/19</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Univ. of Md</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Balt.</i>	
10a. STATE <i>Md</i>				10b. COUNTY <i>Balt.</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>4500 Carleview Road</i>			
10f. ZIP CODE <i>21207</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>William Reed</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Alverta Jones</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Alma Reed</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4500 Carleview Rd. Balto, MD. 21207</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest</i>		20c. LOCATION — City or Town, State <i>Balto, Co., Md</i>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2222 W. North Ave, Balto, MD. 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Coronary artery disease</i> <i>Diabetes mellitus</i> <i>Hypertension</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. Jones MD</i>				29c. LICENSE NUMBER <i>D39718</i>		29d. DATE SIGNED (Month, Day, Year) <i>12/30/92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. Jones 22 S. Greene St.</i>							
31. DATE FILED (Month, Day, Year) <i>JAN 5 1993</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

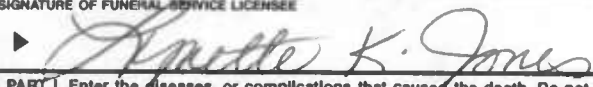
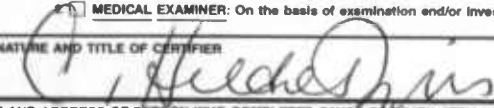
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4+1

92 37211

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN RAY II				2. DATE OF DEATH MONTH 12 DAY 29 YEAR 92		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 242-72-1005		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-9-46	
8. BIRTHPLACE (State or Foreign Country) N.C.				9a. FACILITY NAME (If not institution, give street and number) 111 W. CENTRE STREET		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH				10a. STATE MD		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 111 W. CENTRE STREET APT. 306	
10f. ZIP CODE 21201				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEKEEPING		16b. KIND OF BUSINESS/INDUSTRY ELKRIDGE COUNTRY CLUB	
17. FATHER'S NAME (First, Middle, Last) REV. J.C. GRAY				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE MAE BOLDEN			
19a. INFORMANT'S NAME (Type/Print) GARY WARFIELD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 NORTHBOURNE ROAD/BALTIMORE, MD 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. LOCATION — City or Town, State RANDALLSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST							
DUE TO (OR AS A CONSEQUENCE OF):							
b. HIV DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. 1987							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV DISEASE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 111 W. CENTRE ST.	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  C. HILDRETH, MD				29c. LICENSE NUMBER D38603		29d. DATE SIGNED (Month, Day, Year) 1/4/93	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. HILDRETH, MD							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. FILING OFFICE Johns Hopkins			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37212

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM H. SHEPHERD				2. DATE OF DEATH MONTH DAY YEAR 12 30 92		3. TIME OF DEATH 10:30 A.M.	
4. SOCIAL SECURITY NUMBER 063-54-7770		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-25-43	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) ROSEWOOD CENTER		9b. CITY, TOWN OR LOCATION OF DEATH OWINGS MILLS	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE Maryland		10b. COUNTY	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 410 Normandy Ave.	
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disability				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Harvey Shepherd				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Dorsey			
19a. INFORMANT'S NAME (Type/Print) Mrs. Marnie Shepherd				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Normandy Ave. Baltimore Md 212			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cem 1/6			
20c. LOCATION — City or Town, State BALTO. Co. Md.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph J. Russ			
22. NAME AND ADDRESS OF FACILITY Joseph J. Russ Funeral Home 3252 W. North Ave. Balto. Md. 21216				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PERFORATED STOMACH WITH GASTROHA- DUE TO (OR AS A CONSEQUENCE OF): b. LACED OLD MEGACOLON DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mental Retardation				24a. WAS AN AUTOPSY PERFORMED? XX YES 2 <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Marnie Shepherd				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12-31-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marnie Shepherd 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE John Andrew Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37213

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORIS MARIE STORRER				2. DATE OF DEATH MONTH DAY YEAR 12 - 30 - 92		3. TIME OF DEATH 7:09 PM	
4. SOCIAL SECURITY NUMBER 215-05-7804		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 4, 1918	
9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON		9c. COUNTY OF DEATH HARFORD	
10a. STATE MARYLAND		10b. COUNTY HARFORD		10c. CITY, TOWN OR LOCATION JOPPA		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 418 - R PHILADELPHIA ROAD				10f. ZIP CODE 21085		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) CONRAD BISCHOFF				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA LLOYD			
19a. INFORMANT'S NAME (Type/Print) JOHN W. STORRER, SR. (HUSBAND)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418-R PHILADELPHIA RD., JOPPA, MD 21085			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEMETERY 1/4		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOMES, INC. 9705 BELAIR RD., BALTIMORE, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. ACUTE ANTEROSEPTAL MYOCARDIAL INFARCTION					Approximate Interval Between Onset and Death 15 HRS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
		c. _____					
		d. _____					
		e. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DIGOXIN TOXICITY METABOLIC ACIDOSIS AORTIC INSUFFICIENCY						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas S. Trinchetto, M.D.				29c. LICENSE NUMBER 024991		29d. DATE SIGNED (Month, Day, Year) 12/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS S. TRINCETTO, FALLSTON GENERAL HOSPITAL, FALLSTON, MD.							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 23 PART I, 27, 28a,b, ,d,e,f per MEO G-695 1/6/93 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM MICHAEL SAWYER				2. DATE OF DEATH MONTH 12 DAY 06 YEAR 92		3. TIME OF DEATH 3:00 P M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 48 YRS.	7. DATE OF BIRTH (Month, Day, Year) 3-15-1944		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) 15123 MARLBORO PIKE				9b. CITY, TOWN OR LOCATION OF DEATH UPPER MARLBORO		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE Maryland				10b. COUNTY Prince George Co		10c. CITY, TOWN OR LOCATION Upper Marlboro	
10d. STREET AND NUMBER 15123 Marlboro Pike				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (5-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) ocme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> 12.31.92				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE AND CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) UNKNOWN		28b. TIME OF INJURY UNK. M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED UNKNOWN		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) UNKNOWN		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) UNKNOWN	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G Wright MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/07/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>John Benson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37215

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TIMOTHY WILLIAM SLAYSMAN				2. DATE OF DEATH MONTH DAY YEAR 12 31 92		3. TIME OF DEATH 5:40 P M	
4. SOCIAL SECURITY NUMBER 217-03-9106		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 12, 1915	
9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 5305 Nuth Ave.		10f. ZIP CODE 21206	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yr's College (1-4 or 5+) Steel Worker				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Beth. Steel			
17. FATHER'S NAME (First, Middle, Last) James A. Slaysman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Daly			
19a. INFORMANT'S NAME (Type/Print) Mrs. Anne E. Plempel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Elmbank Ave. Baltimore, MD 21209			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cem. 1/4/93			
20c. LOCATION — City or Town, State Baltimore, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr.			
22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Rd.				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Liver failure PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition, Anemia, Alcoholism			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 1/4/93			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D33405			
29d. DATE SIGNED (Month, Day, Year) 1/4/93				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37216

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAGDALENA SHELLEY				2. DATE OF DEATH MONTH 12 DAY 31 YEAR 92		3. TIME OF DEATH 3:30 P. M.	
4. SOCIAL SECURITY NUMBER 207-40-0580		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-17-1907	
8. BIRTHPLACE (State or Foreign Country) R.I.				9a. FACILITY NAME (If not institution, give street and number) VILLA JULIE INFIRMARY		9b. CITY, TOWN OR LOCATION OF DEATH STEVENSON	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MD.		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION STEVENSON				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1531 GREENSPRING VALLEY RD.	
10f. ZIP CODE 21153				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER				17. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) HENRY F. SHELLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) SUSAN MANSELL			
19a. INFORMANT'S NAME (Type/Print) SR. MARY ADELG				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 GREENSPRING VALLEY RD STEVENSON, MD 21153			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ELLICOTT CITY, MD. DATE 1/29/93			
20c. LOCATION — City or Town, State ELLICOTT CITY, MD 21041				21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]			
22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Delirium Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Alzheimer's disease ASCVD Peripheral vascular disease w/ PPH embolism			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 1/29/93			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Pratima Bose M.D.				29c. LICENSE NUMBER 14628			
29d. DATE SIGNED (Month, Day, Year) 1/1/93				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 301 St. Paul Place Bethesda, MD 20814			
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

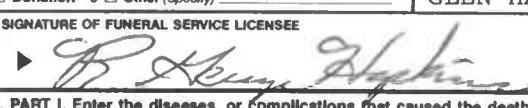
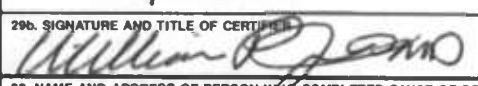
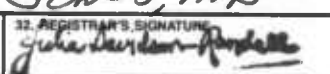
THE DEATH CERTIFICATE BE COMPLETED BY THE FUNERAL DIRECTOR WITHIN 24 HOURS AFTER DEATH. PAGE 6 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. PAGE 5 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. PAGES 1, 2, 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37217

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry Shepeta				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 2248 M	
4. SOCIAL SECURITY NUMBER 173-20-0131		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/29/27	
8a. FACILITY NAME (If not institution, give street and number) North Arundel Hosp				8b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		8c. COUNTY OF DEATH AA	
9. RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1021 FITZALLEN ROAD				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 YEARS College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RIGGER		16b. KIND OF BUSINESS/INDUSTRY MARYLAND DRY DOCK			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) LORETTA M. SHEPETA				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 FITZALLEN ROAD GLEN BURNIE, MD. 21060			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		20c. LOCATION — City or Town, State 1/4/93 GLEN BURNIE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE., S.W., GLEN BURNIE, MD. 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ASCVD DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Deputy				29c. LICENSE NUMBER DC06054		29d. DATE SIGNED (Month, Day, Year) 12/31/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD PO Box 99 20711							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37218

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Philip Gerard Trayser				2. DATE OF DEATH MONTH 12 DAY 30 YEAR 92		3. TIME OF DEATH 10:50 A M	
4. SOCIAL SECURITY NUMBER 219-01-3850		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 1, 1921	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH - - - -				10a. STATE Maryland			
10b. COUNTY - - - -				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 3201 E. Monument St.			
10f. ZIP CODE 21205				10g. CITIZEN OF WHAT COUNTRY? U. S. A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steel Worker		16b. KIND OF BUSINESS/INDUSTRY Steel Company			
17. FATHER'S NAME (First, Middle, Last) James G. Trayser				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Edenfield			
19a. INFORMANT'S NAME (Type/Print) Sylvia Plumley (Dghtr)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1324 Roe Road, Sudlersville, Md. 21668			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wesley Chapel		20c. DATE 1/2/93		20d. LOCATION — City or Town, State Rock Hall, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Uremia DUE TO (OR AS A CONSEQUENCE OF):							
b. Post-renal obstruction DUE TO (OR AS A CONSEQUENCE OF):							
c. Renal failure Bladder carcinoma DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29c. DATE SIGNED (Month, Day, Year) 1-130/91			
29d. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29e. SIGNATURE AND TITLE OF CERTIFIER Ch. Purcell, MD Physician				29f. LICENSE NUMBER 014714		29g. DATE SIGNED (Month, Day, Year) 1-130/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL PRIELL PSKML 4740 EAGLE AVE, BAL MD 21214							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR OTHER PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37219

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) IRENE ELIZABETH TYRE				2. DATE OF DEATH 12 TH 12/29 1992		3. TIME OF DEATH 6:40 a.m.	
4. SOCIAL SECURITY NUMBER 214-32-5008		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/1/1935	
8. BIRTHPLACE (State or Foreign Country) 57				9a. FACILITY NAME (If not institution, give street and number) 12948 Worchester Highway		9b. CITY, TOWN OR LOCATION OF DEATH Bishopville	
9c. COUNTY OF DEATH Worchester				10a. STATE Md.		10b. COUNTY Worchester	
10c. CITY, TOWN OR LOCATION Bishopville,				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12948 Worchester Highway	
10f. ZIP CODE 21813				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) poultry plant worker		16b. KIND OF BUSINESS/INDUSTRY poultry industry	
17. FATHER'S NAME (First, Middle, Last) Moses Purnell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margie E. Mumford			
19a. INFORMANT'S NAME (Type/Print) Mary E. Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12948 Worchester Hwy., Bishopville, Md. 21813			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Curtis Cemetery		20c. LOCATION — City or Town, State Bishopville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard T. Watson				22. NAME AND ADDRESS OF FACILITY Watson Funeral Home, Inc. Millsboro, Delaware			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Ca with Metastatic disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER M. G. G. 2/1				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12-30-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. L. Gonzalez MD Berlin md 21811							
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety, it is to be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completed in its entirety, it is to be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37220

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JANETTE L. TAYLOR				2. DATE OF DEATH MONTH DECEMBER DAY 31 YEAR 1992				3. TIME OF DEATH 6:42 A.	
4. SOCIAL SECURITY NUMBER 266-41-6537		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) APRIL 28, 1899				8. BIRTHPLACE (State or Foreign Country) NEW YORK					
9a. FACILITY NAME (If not institution, give street and number) SUMMIT NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE TEXAS		10b. COUNTY		10c. CITY, TOWN OR LOCATION DALLAS				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7621 OAK BLUFF DRIVE				10f. ZIP CODE 75240				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) CHARLES F. LaMONT				18. MOTHER'S NAME (First, Middle, Maiden Surname) CHRISTINA LOUISE HUMMEL					
19a. INFORMANT'S NAME (Type/Print) JEANNE T. BEATTY (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 ST. THOMAS-EDENVILLE ROAD, ST. THOMAS, PA. 17252					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN MEMORIAL 2/2/93				20c. LOCATION — City or Town, State ORLANDO, FLORIDA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic degenerative Brain Syndrome Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Chronic degenerative Brain Syndrome b. Alzheimer's c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 10y	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 008780				29d. DATE SIGNED (Month, Day, Year) 12-31-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALEJANDRO MEJIA 405 FREDERICK ROAD SUITE 100 CATONSVILLE, MARYLAND 21228									
31. DATE FILED (Month, Day, Year) JAN 5 1993				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Saul</i> SAUL R. WINER		2. DATE OF DEATH MONTH <i>12</i> DAY <i>29</i> YEAR <i>1992</i>		3. TIME OF DEATH 7:20 P. M.	
4. SOCIAL SECURITY NUMBER 477-09-6782	5. SEX <i>M</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JAN. 24, 1907
8. FACILITY NAME (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL			9. CITY, TOWN OR LOCATION OF DEATH COLUMBIA		10. COUNTY OF DEATH ILLINOIS
11. RESIDENCE OF DECEDENT 10a. STATE MARYLAND			10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION COLUMBIA
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			10e. STREET AND NUMBER 5460 GLOUCESTER ROAD		
10f. ZIP CODE 21044			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER	
16b. KIND OF BUSINESS/INDUSTRY BOOK STORE		17. FATHER'S NAME (First, Middle, Last) ISRAEL WINER		18. MOTHER'S NAME (First, Middle, Maiden Surname) AUGUSTA BROWN	
19a. INFORMANT'S NAME (Type/Print) JANE WINER (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10118 HYL A BROOK ROAD, COLUMBIA, MARYLAND 21044			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of METRO CREMATORY		20c. LOCATION — City or Town, State CATONSVILLE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M. Witzke</i>		22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive heart failure</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Pneumonia</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal failure</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Intervist</i>		29c. LICENSE NUMBER D37013		29d. DATE SIGNED (Month, Day, Year) 12/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B CONGER, MD #205, 11055 Little Patuxent Pky, Columbia, MD 21044					
31. DATE FILED (Month, Day, Year) JAN 5 1993		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23170

Representative 1914



92 37222

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY LOUISE ALBAUGH				2. DATE OF DEATH MONTH DAY YEAR Dec. 24, 1992		3. TIME OF DEATH 4:40PM M	
4. SOCIAL SECURITY NUMBER 213-36-7661		5. SEX FEMALE		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03/11/10	
9a. FACILITY NAME (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH FREDERICK		9c. COUNTY OF DEATH FREDERICK	
10a. STATE MD		10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION UNION BRIDGE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 13405 RABBIT RUN TERRACE				10f. ZIP CODE 21791		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: NO		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) JOHN RIPPEON				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA ZIMMERMAN			
19a. INFORMANT'S NAME (Type/Print) THOMAS T. ALBAUGH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13405 RABBIT RUN TER UNION BRIDGE MD 21791			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) BURIAL		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FAIRMOUNT CEMETERY		20c. LOCATION — City or Town, State LIBERTYTOWN, MD		20d. DATE DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Catherine D. Hartzler				22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS LIBERTYTOWN, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 5"							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 4 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William O. Miller, MD				29c. LICENSE NUMBER D14373		29d. DATE SIGNED (Month, Day, Year) 12/27/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William O. Miller, MD 804 Baltimore Ave Frederick, MD							
31. DATE FILED (Month, Day, Year) DEC 28 '92		32. REGISTRAR'S SIGNATURE John F. Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37223

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>LINDA M. BORTNER</i>		2. DATE OF DEATH MONTH <i>12</i> DAY <i>27</i> YEAR <i>92</i>		3. TIME OF DEATH <i>5:22 AM</i>	
4. SOCIAL SECURITY NUMBER <i>171-46-4915</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>39</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>12/20/53</i>		8. BIRTHPLACE (State or Foreign Country) <i>York, PA</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>University of MD med. Ctr.</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
10a. STATE <i>PA</i>		10b. COUNTY <i>York</i>		10c. CITY, TOWN OR LOCATION <i>W. Manchester Twp.</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>4625 Wolf's Church Rd.</i>		10f. ZIP CODE <i>17404</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (14 or 5+) <i>0</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Vacuum Cleaner Sales</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Glenn W. Ziegler</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Tillieann Bupp</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Richard A. Bortner</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4625 Wolf's Church Rd., York, PA 17404</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Paul's (Wolf's) Cem 12/30/92</i>		20c. LOCATION — City or Town, State <i>York, PA</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Luwin</i>		22. NAME AND ADDRESS OF FACILITY <i>Sauter Funeral Home 175 N. main St., Spring Grove, PA 17362</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>SUBARACHNOID HEMORRHAGE</i>		Approximate Interval Between Onset and Death <i>DAYS</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>CEREBRAL EDEMA</i>		<i>DAYS</i>	
		c. <i>CEREBRAL INFARCTION</i>		<i>DAYS</i>	
		d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Swartz</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>12/27/92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>R. Swartz, MD DEPT. OF NEUROSURGERY, UNIV OF MD MED. CTR</i>					
31. DATE FILED (Month, Day, Year) <i>12/27/92</i>		32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37224

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS S. BLUBAUGH				2. DATE OF DEATH MONTH DAY YEAR December 15, 1992		3. TIME OF DEATH 8:45 AM	
4. SOCIAL SECURITY NUMBER 217-14-4036		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-17-1922	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE PA		10b. COUNTY Bedford		10c. CITY, TOWN OR LOCATION Bedford		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt 3 - Hazen Road				10f. ZIP CODE 15522		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) retired		16b. KIND OF BUSINESS/INDUSTRY Telephone Co.			
17. FATHER'S NAME (First, Middle, Last) Thomas W. Blubaugh				18. MOTHER'S NAME (First, Middle, Maiden Surname) Violet Clites			
19a. INFORMANT'S NAME (Type/Print) Mrs. Audrey V. Blubaugh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3 - Hazen Road Bedford, PA 15522			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park		DATE 12-18		20c. LOCATION — City or Town, State Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James Z Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → COPD a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiopulmonary arrest							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Qamar Zaman				29c. LICENSE NUMBER D 23371		29d. DATE SIGNED (Month, Day, Year) 12/14/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Qamar Zaman Johnson Heights Medical Bdlg Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 17 1992		32. REGISTRAR'S SIGNATURE John Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been approved by an attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COLLIER FIELD
WOOD

approximately 100

92 37225

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH A. BECHTOLD				2. DATE OF DEATH MONTH DAY YEAR 12/13/92		3. TIME OF DEATH 10:30 P. M.	
4. SOCIAL SECURITY NUMBER 177-09-5034		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-06-1897	
8a. FACILITY NAME (If not institution, give street and number) 145 WINSLOW STREET				8b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		8c. COUNTY OF DEATH ALLEGANY	
9a. RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY Allegany 10c. CITY, TOWN OR LOCATION Cumberland 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 145 Winslow Street		10f. ZIP CODE 21502	
11. MARITAL STATUS <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) tool & dye maker		16b. KIND OF BUSINESS/INDUSTRY steel co.			
17. FATHER'S NAME (First, Middle, Last) Leo Bechtold				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Wems			
19a. INFORMANT'S NAME (Type/Print) Robert F. Leipheimer Funeral Home				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1246 Roemer Blvd. Farrell, PA 16121			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Elizabeth Cemetery 12-17		20c. LOCATION — City or Town, State Farrell, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Heart Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Coronary Heart Failure b. Coronary Artery Disease c. d. 						Approximate Interval Between Onset and Death mos mos	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER DR. GUY FISCUS, M.D.		29c. LICENSE NUMBER D12779		29d. DATE SIGNED (Month, Day, Year) 12/14/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GUY FISCUS, M.D., 500 MEMORIAL AVENUE, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 16 1992		32. REGISTRAR'S SIGNATURE G. Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director's copy should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37226

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN R. BLANK				2. DATE OF DEATH MONTH DAY YEAR December 8, 1992		3. TIME OF DEATH 12:08 A M	
4. SOCIAL SECURITY NUMBER 215-20-5365		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-24-1926	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Mt. Savage		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt. 1, Box 203				10f. ZIP CODE 21545		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) David J. Powell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura M. Gordon			
19a. INFORMANT'S NAME (Type/Print) Edgar A. Blank				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 203, Mt. Savage, Md. 21545			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Methodist Cemetery		DATE 12/10		20c. LOCATION — City or Town, State Mt. Savage, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Harn</i>				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home, Frostburg, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { CVA and acute GI Bleed PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obstructive Arterial Disease						Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Terry Williams</i>				29c. LICENSE NUMBER D16041		29d. DATE SIGNED (Month, Day, Year) 12-9-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Terry Williams Memorial Hospital Medical Building Cumberland, MD. 21502							
31. DATE FILED (Month, Day, Year) DEC 15 1992		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2007-2008

92 37227

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JESSIE VALOTTA BOONE				2. DATE OF DEATH MONTH 12 DAY 9 YEAR 92		3. TIME OF DEATH 9:30 P M	
4. SOCIAL SECURITY NUMBER 215-26-7578		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-08-1898	
8a. FACILITY NAME (If not institution, give street and number) Cumberland Nursing Home				8b. CITY, TOWN OR LOCATION OF DEATH Cumberland		8c. COUNTY OF DEATH WV	
9a. STATE MD				9b. COUNTY Allegany		9c. CITY, TOWN OR LOCATION Cumberland	
10a. STREET AND NUMBER 15 Pennsylvania Avenue				10b. ZIP CODE 21502		10c. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Robert Garrett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Tempa			
19a. INFORMANT'S NAME (Type/Print) Mrs. Norita L. Morris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park 12-14		20c. LOCATION — City or Town, State Cumberland, MD		20d. SIGNATURE OF FUNERAL SERVICE LICENSEE James J. Scarpelli	
21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration pneumonia		22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502		23a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		23b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		25. DUE TO (OR AS A CONSEQUENCE OF):		26. DUE TO (OR AS A CONSEQUENCE OF):		27. DUE TO (OR AS A CONSEQUENCE OF):	
28. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		29. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBS		30. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		31. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
32. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		33a. DATE OF INJURY (Month, Day, Year)		33b. TIME OF INJURY M		33c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
34. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		35. LOCATION (Street and Number or Rural Route Number, City or Town, State)		36. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		37. SIGNATURE AND TITLE OF CERTIFIER Robert J. Calum MD	
38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. HAZARD 301 Schley St Cumberland, MD		39. LICENSE NUMBER D04981		39d. DATE SIGNED (Month, Day, Year) 12/10/92		40. DATE FILED (Month, Day, Year) DEC 15 1992	
41. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 29 is marked, or item 30 is marked, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37228

1. DECEDENT'S NAME (First, Middle, Last) PAUL BREEDING				2. DATE OF DEATH MONTH 12 DAY 17 YEAR 92				3. TIME OF DEATH 7:35P M			
4. SOCIAL SECURITY NUMBER 220019830		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/10/15		8. BIRTHPLACE (State or Foreign Country) GREENSBORO, Md.			
9a. FACILITY NAME (If not institution, give street and number) Perry Point Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point				9c. COUNTY OF DEATH Balt			
10a. STATE MD		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER Rt. 50-Meridan the Pines Nursing Hm.				10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) laborer		16b. KIND OF BUSINESS/INDUSTRY Mudmill Feed & Grain							
17. FATHER'S NAME (First, Middle, Last) William Breeding				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Thorpe Breeding							
19a. INFORMANT'S NAME (Type/Print) Wanda Nieves				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. box 434 Triangle, VA 22172							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro Cm		DATE 12-20		20c. LOCATION — City or Town, State Greensboro, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kuplin (Signature)				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Fn Hm 106 Sunset Ave Greensboro, M 21639							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Stanley Green						29c. LICENSE NUMBER MD H41069		29d. DATE SIGNED (Month, Day, Year) 12-17-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) DEC 28 '92				32. REGISTRAR'S SIGNATURE J. W. Anderson-Randall							

92 37229

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HOWARD LEO BORDER				2. DATE OF DEATH MONTH 12 DAY 5 YEAR 1992		3. TIME OF DEATH 2:15 PM	
4. SOCIAL SECURITY NUMBER 216-03-4969		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-14-1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) #7 St. James Court, Hyde Park		9b. CITY, TOWN OR LOCATION OF DEATH Easton	
9c. COUNTY OF DEATH Talbot				10a. STATE Maryland		10b. COUNTY Talbot	
10c. CITY, TOWN OR LOCATION Easton				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER #7 St. James Court, Hyde Park	
10f. ZIP CODE 21601				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales person				16b. KIND OF BUSINESS/INDUSTRY Elevator company			
17. FATHER'S NAME (First, Middle, Last) Howard Leo Border, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Mae Anderson			
19a. INFORMANT'S NAME (Type/Print) Mary Helen Border				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #7 St. James Court, Hyde Park, Easton, MD			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Memorial Park 12-8 Easton, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCER, CFS				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Heart Failure DUE TO (OR AS A CONSEQUENCE OF): ASCD & hx Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): and pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William H. Wood, Jr. MD				29c. LICENSE NUMBER D08715		29d. DATE SIGNED (Month, Day, Year) 12/7/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William H. Wood, Jr., M.D., 506 Idlewild Avenue, Easton, MD 21601							
31. DATE FILED (Month, Day, Year) DEC - 7 1992				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Mr. [illegible]
[illegible]
[illegible]

City of [illegible]
[illegible]
[illegible]

92 37230

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE BYINGTON				2. DATE OF DEATH MONTH 12 / DAY 16 / YEAR 92		3. TIME OF DEATH 10:35 AM	
4. SOCIAL SECURITY NUMBER 45-46-4451		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-07-28		8. BIRTHPLACE (State or Foreign Country) Tenn.
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 9538 Blackdog Alley D. 8				10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 3rd grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Farming			
17. FATHER'S NAME (First, Middle, Last) George Byington Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Davis			
19a. INFORMANT'S NAME (Type/Print) Ola Mae Byington				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9538 Blackdog Alley D.8, Easton, MD 21601			
20a. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Removal from State 4 Donation 8 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory 12-17		20c. LOCATION — City or Town, State Salisbury, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCERON CFS				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive Cerebral Infarct DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 X Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Christian Head - Surgical Intern				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 12/16/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christian S. Head 2405 Old Trace Lane Reston, Va. 22091							
31. DATE FILED (Month, Day, Year) 12/16/92		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 18 1992

92 37231

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA MAE COLLINS				2. DATE OF DEATH MONTH DAY YEAR December 22, 1992		3. TIME OF DEATH 11:03 a.m.	
4. SOCIAL SECURITY NUMBER 219-14-6150		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 19 1922	
8. BIRTHPLACE (State or Foreign Country) PENNA.				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 701 FURNANCE STREET	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEKEEPER		16b. KIND OF BUSINESS/INDUSTRY HOUSE KEEPER	
17. FATHER'S NAME (First, Middle, Last) CALVIN BRUNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA OLIVER			
19a. INFORMANT'S NAME (Type/Print) JOYCE SHIPLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8375 OLD COLUMBIA ROAD, LAUREL MARYLAND 20723			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET CEMETERY DEC 24 1992		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Aspiration Pneumonia</i> <i>CVA and</i> <i>COVID</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D 16041		29d. DATE SIGNED (Month, Day, Year) 12-24-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Williams, M.D.. Memorial Hospital Medical Building, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 24 1992				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DECEMBER 1930

92 37232

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILARY JOSEPH CAVEY				2. DATE OF DEATH MONTH DECEMBER DAY 13 YEAR 1992		3. TIME OF DEATH 07:45A	
4. SOCIAL SECURITY NUMBER 214074745		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-11-1919	
8a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				8b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		8c. COUNTY OF DEATH ALLEGANY	
9. RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Frostburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 128 Walnut St.				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. 2		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Millwright		16b. KIND OF BUSINESS/INDUSTRY Paper Co.			
17. FATHER'S NAME (First, Middle, Last) Joseph Cavey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Cabbage			
19a. INFORMANT'S NAME (Type/Print) Edith L. Cavey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Walnut St., Frostburg, Md. 21532			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Memorial Park 12/15 Frostburg, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Horn</i>				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home, Frostburg, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-respiratory arrest DUE TO (OR AS A CONSEQUENCE OF): b. End stage C.H.F. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Uriel Velandia</i>				29c. LICENSE NUMBER D08377		29d. DATE SIGNED (Month, Day, Year) 12-15-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) URIEL VELANDIA, M.D. 924 SETON DRIVE CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 16 1992				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37233

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mabel Dill Curry				2. DATE OF DEATH MONTH DAY YEAR 12 27 92		3. TIME OF DEATH 3:24 a m	
4. SOCIAL SECURITY NUMBER 221-16-8610		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 27, 1905	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Community Care Home		9b. CITY, TOWN OR LOCATION OF DEATH Greensboro	
9c. COUNTY OF DEATH Caroline				10a. STATE MD		10b. COUNTY Caroline	
10c. CITY, TOWN OR LOCATION Greensboro				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Hill Road	
10f. ZIP CODE 21639				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) food preparer		15b. KIND OF BUSINESS/INDUSTRY Caroline School System	
17. FATHER'S NAME (First, Middle, Last) Bates Dill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura (unknown) Dill			
19a. INFORMANT'S NAME (Type/Print) J. Paul Curry, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 185 Highview Ave. Dover, Delaware 19901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro Cemetery 12-30		20c. LOCATION — City or Town, State Greensboro, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Fleegel-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CVA</i> <i>OBS</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Home Care facility</i>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marlene A. Bielecki MD</i>				29c. LICENSE NUMBER D41503		29d. DATE SIGNED (Month, Day, Year) 12/28/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Marlene A. Bielecki MD</i>				30. ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>PO Box 496 Denton MD</i>			
31. DATE FILED (Month, Day, Year) DEC 31 92				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1003

1003

1003

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILSON H. CLOUGH				2. DATE OF DEATH MONTH 12 DAY 24 YEAR 1992		3. TIME OF DEATH 3:56 PM					
4. SOCIAL SECURITY NUMBER 217-12-4295		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 20 1923		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) EASTON HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH EASTON			9c. COUNTY OF DEATH CAROLINE				
10a. STATE MD		10b. COUNTY Caroline		10c. CITY, TOWN OR LOCATION Greensboro			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 104 Gramby Street				10f. ZIP CODE 21639			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARRIAGE STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) line worker		15b. KIND OF BUSINESS/INDUSTRY Pet Milk Company							
17. FATHER'S NAME (First, Middle, Last) James A. Clough				16. MOTHER'S NAME (First, Middle, Maiden Surname) Addie L. Tharp Clough							
19a. INFORMANT'S NAME (Type/Print) Susan Ann Clough				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Gramby St. Greensboro, MD 21639							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro CM		DATE 12-29		20c. LOCATION — City or Town, State Greensboro, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Thoracic injuries Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12/24/1992		28b. TIME OF INJURY 2:49 PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED AUTO DRIVER IN AUTO/IMPACT			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) PUBLIC STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) CEDAR LANE MAIN STREET GREENSBORO, MD					
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MARYLAND <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12/25/1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ANN DIXON M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) DEC 31 '92				32. REGISTRAR'S SIGNATURE 							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

92 37235

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GORDON R. CHARLES				2. DATE OF DEATH MONTH 12 DAY 10 YEAR 1992		3. TIME OF DEATH 10:55 AM	
4. SOCIAL SECURITY NUMBER 215-12-3665		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 4 1922	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 27970 Holly Road		9b. CITY, TOWN OR LOCATION OF DEATH Easton		9c. COUNTY OF DEATH Talbot	
10a. STATE Maryland				10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 27970 Holly Road			
10f. ZIP CODE 21601				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Pharmaceutical			
17. FATHER'S NAME (First, Middle, Last) William G. Charles				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elsie Trice			
19a. INFORMANT'S NAME (Type/Print) Steven A. Charles				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Roland Avenue, Baltimore, MD 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Unity Washington Cemetery 12-14 Hurlock, MD		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN B. MERCERON CFS				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple pulmonary emboli						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Phyllis K. Oude				29c. LICENSE NUMBER D14537		29d. DATE SIGNED (Month, Day, Year) 12 11 92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregg Rhodes, M.D., 503 Dutchmans' Lane, Easton, MD 21601							
31. DATE FILED (Month, Day, Year) DEC 14 1992				32. REGISTRAR'S SIGNATURE Arvidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OFFICE OF
THE ATTORNEY GENERAL
STATE OF NEW YORK

92 37236

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ETHEL SINCLAIR CALLIS				2. DATE OF DEATH MONTH 12 DAY 10 YEAR 1992		3. TIME OF DEATH 6:15 PM	
4. SOCIAL SECURITY NUMBER 215-26-2725		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-20-1896	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Tilghman		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Gibsonstown Road				10f. ZIP CODE 21671		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11 Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Robert J. Ridgeway				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace L. Sinclair			
19a. INFORMANT'S NAME (Type/Print) Linda Ellen Lee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8737 Littlewood Rd., Baltimore, MD 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Tilghman Methodist Ceme. 12-15 Tilghman, MD		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCERON (FSP)				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Probable Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1 day 7 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BILATERAL PNEUMONIA PARTIAL BOWEL OBSTRUCTION							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER ATTEWING MD				29c. LICENSE NUMBER D30951		29d. DATE SIGNED (Month, Day, Year) 12-10-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AT LUGCO 74 MAIDEN CHOICE LANE CATONSVILLE MA 21228							
31. DATE FILED (Month, Day, Year) DEC 14 1992				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

ITEM: 23 PART I, PER M.D. G-695 1/5/93 reb

92 37237

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL HALL DYSON				2. DATE OF DEATH MONTH DAY YEAR December 10, 1992		3. TIME OF DEATH 2:15 A M	
4. SOCIAL SECURITY NUMBER 215-68-7369		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 28, 1960	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) 2108 Thomas Run Road				9b. CITY, TOWN OR LOCATION OF DEATH Bel Air		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2108 Thomas Run Road				10f. ZIP CODE 21015		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor, Storage Room		16b. KIND OF BUSINESS/INDUSTRY Catering			
17. FATHER'S NAME (First, Middle, Last) Tommy Hall Dyson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Rosemond Campbell			
19a. INFORMANT'S NAME (Type/Print) Elizabeth R. Burton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 Thomas Run Road, Bel Air, Md. 21015			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens		DATE		20c. LOCATION — City or Town, State Bel Air, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard K. McComas III				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC malignant melanoma a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Katharine S. Harrison MD 29c. LICENSE NUMBER D35712 29d. DATE SIGNED (Month, Day, Year) 12/10/92 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. HARRISON MD. Moore Clinic Johns Hopkins Hosp. Balto MD 21205 31. DATE FILED (Month, Day, Year) DEC 11 '92 32. REGISTRAR'S SIGNATURE Jake Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37238

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES MARY DEVORE				2. DATE OF DEATH MONTH 12 DAY 22 YEAR 1992				3. TIME OF DEATH 7:20 P M	
4. SOCIAL SECURITY NUMBER 213 74 3478		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/03/1902		8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MARYLAND				9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION ELLERSLIE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER P O BOX 300				10f. ZIP CODE 21529		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) HOWARD BOHN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAURA WOLFORD					
19a. INFORMANT'S NAME (Type/Print) WINSTON R. DEVORE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLERSLIE, MD 21529					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ROSE HILL CEMETERY 12/24/92 CUMBERLAND, MD				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harvey H. Zeigler</i>				22. NAME AND ADDRESS OF FACILITY HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD - Cardiac + Renal Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Wayne Spiggle</i>				29c. LICENSE NUMBER 011443		29d. DATE SIGNED (Month, Day, Year) 12-23-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. WAYNE SPIGGLE, M.D., B.M.G., 912 SETON DRIVE, CUMBERLAND, MD 21502									
31. DATE FILED (Month, Day, Year) DEC 24 1992		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 25 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37239

1. DECEDENT'S NAME (First, Middle, Last) JANIS M DUGAN				2. DATE OF DEATH MONTH 12 DAY 17 YEAR 92		3. TIME OF DEATH 2:08 P M					
4. SOCIAL SECURITY NUMBER 218-98-6737		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 28 64		8. BIRTHPLACE (State or Foreign Country) Pa.			
9a. FACILITY NAME (If not institution, give street and number) FROSTBURG HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH FROSTBURG				9c. COUNTY OF DEATH ALLEGANY			
10a. STATE Md.		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Frostburg				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER Rt. 2, Box 374				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Bernard C. Drees				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Baer							
19a. INFORMANT'S NAME (Type/Print) William G. Dugan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2, Box 374, Frostburg, Md. 21532							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Memorial Park 12/19 Frostburg, Md.		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John P. Horne				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home, Frostburg, Md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. suicide by hanging Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. long standing depression c. d.								Approximate Interval Between Onset and Death 1 hr 11 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 12 17 92		28b. TIME OF INJURY noon M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED death by suicide - hanging			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Rt 2 Box 374 Frostburg MD		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) (HOME)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Donald Manger		29c. LICENSE NUMBER 90 9231		29d. DATE SIGNED (Month, Day, Year) 12 17 92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DONALD F. MANGER, M. D., 70 MAIN STREET, LONA CONING, MD. 21539											
31. DATE FILED DEC 18 1992		32. REGISTRAR'S SIGNATURE John A. Davidson									

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RECEIVED 11/25/52

92 37240

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward D. Dawson Sr.				2. DATE OF DEATH MONTH DAY YEAR December 13 92		3. TIME OF DEATH 4:07 p.m.	
4. SOCIAL SECURITY NUMBER 212-38-6116		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-21-1940	
8. BIRTHPLACE (State or Foreign Country) MD							
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE WV		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Carpendale		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Route 1 Box 412				10f. ZIP CODE 26753		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1959-65		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) postal clerk		16b. KIND OF BUSINESS/INDUSTRY Post Office			
17. FATHER'S NAME (First, Middle, Last) Robert A. Dawson, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Eckard			
19a. INFORMANT'S NAME (Type/Print) Mrs. Carol L. Dawson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 412 Carpendale, WV 26753			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 12-17		20c. LOCATION — City or Town, State LaVale, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Ventricular Asystole</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>immediate</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>immediate</i>	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Bollino</i>				29c. LICENSE NUMBER D17565		29d. DATE SIGNED (Month, Day, Year) 12/16/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr Bollino 955 Frederick Street Cumberland Maryland 21502							
31. DATE FILED (Month, Day, Year) DEC 17 1992		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

92 37241

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) V ERNIE F. DILL				2. DATE OF DEATH MONTH DAY YEAR December 19, 1992		3. TIME OF DEATH 06 25 M	
4. SOCIAL SECURITY NUMBER 213-24-2114		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-30-25	
8a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				8b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		8c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE De.		10b. COUNTY KENT		10c. CITY, TOWN OR LOCATION WYOMING		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER RD 3 Box 560				10f. ZIP CODE 19934		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) JANITOR		16b. KIND OF BUSINESS/INDUSTRY PUBLIC SCHOOLS			
17. FATHER'S NAME (First, Middle, Last) WARREN DILL				18. MOTHER'S NAME (First, Middle, Maiden Surname) GRACE BELL			
19a. INFORMANT'S NAME (Type/Print) ETHEL DILL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 3 Box 560 WYOMING, DE. 19934			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olive Cemetery 12-22		20c. LOCATION — City or Town, State Sandtown, De.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE William A. Berry, Jr.				22. NAME AND ADDRESS OF FACILITY Berry Funeral Home, Inc. P.O. Box 202 Milford, Delaware 19963			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiogenic shock</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Acute extensive myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Atherosclerotic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert A. Rader				29c. LICENSE NUMBER D19289		29d. DATE SIGNED (Month, Day, Year) 12/19/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert A. Rader M.D. PO Box 2636 Salisbury MD 21801							
31. DATE FILED (Month, Day, Year) DEC 23 '92		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

very good for 50 miles

92 37242

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Christine Dunn</u>						2. DATE OF DEATH MONTH <u>12</u> DAY <u>14</u> YEAR <u>92</u>		3. TIME OF DEATH <u>1 20 AM</u>	
4. SOCIAL SECURITY NUMBER <u>156-20-3741</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>64</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	
7a. FACILITY NAME (If not institution, give street and number) <u>Meridian</u>						7b. CITY, TOWN OR LOCATION OF DEATH <u>Severna Park</u>		7c. COUNTY OF DEATH <u>ANNE</u>	
10a. STATE <u>MD.</u>						10b. COUNTY <u>2.A.</u>		10c. CITY, TOWN OR LOCATION <u>Severna Park</u>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						10e. STREET AND NUMBER <u>24 Treckhouse Rd.</u>		10f. ZIP CODE <u>21146</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>						11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify <u>BLK</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Education</u>						16b. KIND OF BUSINESS/INDUSTRY <u>Teaching</u>			
17. FATHER'S NAME (First, Middle, Last) <u>James Dalbey</u>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Allen Lee</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Laurence Dunn Jr.</u>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>P.O. Box 534 Chester MD 21619</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Union Wesley</u>		20c. LOCATION — City or Town, State <u>Chester Md</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Eric L. Darshell</u>						22. NAME AND ADDRESS OF FACILITY <u>322 East Ave 21619</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u>									
DUE TO (OR AS A CONSEQUENCE OF): <u>Conc</u>									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
DUE TO (OR AS A CONSEQUENCE OF): <u>midbrain tumor</u>									
DUE TO (OR AS A CONSEQUENCE OF): <u>Cerebrovascular disease</u>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u> <u>Cerebral atherosclerotic heart disease</u>									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u> </u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFY (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF PHYSICIAN <u>Guy C. Sammons</u>						29c. LICENSE NUMBER <u>DD8314</u>		29d. DATE SIGNED (Month, Day, Year) <u>12/15/92</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>George C. Sammons MD 205 Ridgely Ave Annapolis, MD</u>									
31. DATE FILED (Month, Day, Year) <u>DEC 15 1992</u>						32. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be filled out by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF

IN SENATE, January 2, 1902.

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1901.

92 37243

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Gertrude Davis						2. DATE OF DEATH MONTH DAY YEAR 12 25 1992		3. TIME OF DEATH 10:13 a. M	
4. SOCIAL SECURITY NUMBER 216-38-5851		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-11-1910		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH LaPlata		9c. COUNTY OF DEATH Charles	
10a. STATE Maryland						10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Nanjemoy	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER Box 315 LiverPool RD.						10f. ZIP CODE 20662		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16. KIND OF BUSINESS/INDUSTRY Home					
17. FATHER'S NAME (First, Middle, Last) Ernest F. Posey						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary F. Franklin			
19a. INFORMANT'S NAME (Type/Print) Donald E. Davis						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 315 LiverPool Rd. Nanjemoy, MD 20662			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Nanjemoy Baptist Cem. 12/28 Nanjemoy, MD		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Arehart-Echols</i>						22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, Inc. P.O. Box 567 LaPlata, MD 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ruptured thoracic Aneurysm</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Advanced Atherosclerosis</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature]</i>		29c. LICENSE NUMBER D20624		29d. DATE SIGNED (Month, Day, Year) 12/25/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) G. W. VARTAN LAPlata, Md 20646									
31. DATE FILED (Month, Day, Year) DEC 28 '92		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pondette</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37244

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wiley Monroe Davis				2. DATE OF DEATH MONTH 12 DAY 23 YEAR 92		3. TIME OF DEATH 10:05 A.M.	
4. SOCIAL SECURITY NUMBER 245-16-9380		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/1/14	
8. BIRTHPLACE (State or Foreign Country) NC				9a. FACILITY NAME (If not institution, give street and number) Carroll County Gen. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE MD		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2501 Halter Road	
10f. ZIP CODE 21158				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) truck driver		16b. KIND OF BUSINESS/INDUSTRY 3M			
17. FATHER'S NAME (First, Middle, Last) Arch Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Francis			
19a. INFORMANT'S NAME (Type/Print) Mrs. Mable Yelton Davis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Halter Road, Westminster, MD 21158			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Lutheran Cemetery 12/27		20c. LOCATION — City or Town, State Manchester, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert K. Pritts, Sr.				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive (L) CVA (R) hemiparesis DUE TO (OR AS A CONSEQUENCE OF): b. S/P (R) CVA (L) hemiparesis DUE TO (OR AS A CONSEQUENCE OF): c. ASWD S/P Aortic valve replacement DUE TO (OR AS A CONSEQUENCE OF): d. Actual Abolletier Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Khay Fong MD					
29c. LICENSE NUMBER D38915		29d. DATE SIGNED (Month, Day, Year) 12/23/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PREISI 542 WASH RD westminster							
31. DATE FILED (Month, Day, Year) DEC 28 '92		32. REGISTRAR'S SIGNATURE John Burden-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1951

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

5. The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.

6. The sixth part of the report deals with the environmental situation of the country. It is a very interesting and informative study of the country's environmental development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's environmental development.

7. The seventh part of the report deals with the international situation of the country. It is a very interesting and informative study of the country's international development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's international development.

8. The eighth part of the report deals with the future of the country. It is a very interesting and informative study of the country's future development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's future development.

92 37245

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BETTY JANE EDMISTON				2. DATE OF DEATH MONTH DAY YEAR December 9, 1992		3. TIME OF DEATH 9:50 P M	
4. SOCIAL SECURITY NUMBER 215-20-5136		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-09-1925	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE MD				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER Route 8 Box 419-Valley Road			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Elmer E. Bridges				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Elizabeth O'Baker			
19a. INFORMANT'S NAME (Type/Print) Mr. Harry D. Edmiston, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 8 Box 419-Valley Road Cumberland MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park 12-12		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Irreversible Shock DUE TO (OR AS A CONSEQUENCE OF): b. Possibly Severe Pancreatitis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastatic Colon Ca							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Kenneth Rock				29c. LICENSE NUMBER D 30159		29d. DATE SIGNED (Month, Day, Year) 12/10/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Kenneth Rock, Memorial Hospital, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 15 1992				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37246

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA FOLMAR				2. DATE OF DEATH MONTH DAY YEAR December 28, 1992				3. TIME OF DEATH 3:35 P M					
4. SOCIAL SECURITY NUMBER 232-58-0109		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 11-17-20		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Cumberland			9c. COUNTY OF DEATH Allegany				
RESIDENCE OF DECEDENT													
10a. STATE Ohio		10b. COUNTY		10c. CITY, TOWN OR LOCATION Bellaire,				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 3345 Monroe Street						10f. ZIP CODE 43906		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify:					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LPN				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Charles Albert Lish						18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Grace Lish							
19a. INFORMANT'S NAME (Type/Print) HGR-WVU Records						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4052, HSN, Morgantown, WV 26506							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Omega Crematory				20c. LOCATION — City or Town, State Morgantown, WV					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY HGR-WVU 4052 HSN, Morgantown, WV 26506							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Brain Stem Infarction										Approximate Interval Between Onset and Death days			
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Myocardial Infarction													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D 17862 (D33280)		29d. DATE SIGNED (Month, Day, Year) 12/28/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. S. Harshberger, 925 Seton Drive, Cumberland, MD 21502													
31. DATE FILED (Month, Day, Year) JAN 05 1993				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37248

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TERESA AGNES FIRLIE				2. DATE OF DEATH MONTH DECEMBER DAY 8 YEAR 1992				3. TIME OF DEATH 5:30 P M	
4. SOCIAL SECURITY NUMBER 214057502		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7. DATE OF BIRTH (Month, Day, Year) 03-21-1915				8. BIRTHPLACE (State or Foreign Country) MD					
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland				9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MD				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 307B Mt. View Drive				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) former employee		16b. KIND OF BUSINESS/INDUSTRY McCroy's			
17. FATHER'S NAME (First, Middle, Last) Peter Firlie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Duggan					
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Elbis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7705 Barnum Road Bethesda, MD 20817					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) SS Peter Paul Cemetery 12-14		DATE 12-9-92		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute pneumonia Severe leg lower extremity								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Wagoner</i>				29c. LICENSE NUMBER 022181		29d. DATE SIGNED (Month, Day, Year) 12-9-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GARY WAGONER, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502									
31. DATE FILED (Month, Day, Year) DEC 15 1992				32. REGISTRAR'S SIGNATURE <i>Gale Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37247

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEONA ROSE FREELAND				2. DATE OF DEATH MONTH DAY YEAR December 16, 1992 6:40A M		3. TIME OF DEATH 6:40A M	
4. SOCIAL SECURITY NUMBER 176-44-3653		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 24 1906	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 220 SOMERVILLE AVE.	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) HOUSE KEEPER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE KEEPER		16b. KIND OF BUSINESS/INDUSTRY HOUSE KEEPER	
17. FATHER'S NAME (First, Middle, Last) JOHN JOSEPH GOODYEAR				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA ELIZABETH FROST			
19a. INFORMANT'S NAME (Type/Print) ELMER JOHN FREELAND				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 171 EXECUTIVE CIRCLE RADCLIFF, KENTUCKY 40160			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) REST LAWN CEMETERY DEC 18 1992		20c. LOCATION — City or Town, State LAVALE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Renal Failure							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Heart Disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Barrera</i>				29c. LICENSE NUMBER D 14865		29d. DATE SIGNED (Month, Day, Year) 12-16-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Dr. Barrera Memorial Hospital & Medical Center Medical Building Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 17 1992				32. REGISTRAR'S SIGNATURE <i>J. A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37249

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OWEN KYTE FOX				2. DATE OF DEATH MONTH DAY YEAR DEC. 5, 1992		3. TIME OF DEATH 6:50 A.M.	
4. SOCIAL SECURITY NUMBER 071-14-6191		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/13/1921	
8. BIRTHPLACE (State or Foreign Country) NEW YORK				9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH EASTON	
9c. COUNTY OF DEATH TALBOT				10a. STATE MARYLAND		10b. COUNTY QUEEN ANNE'S	
10c. CITY, TOWN OR LOCATION CHURCH HILL				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER R.D. #1, BOX 53 BA	
10f. ZIP CODE 21623				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREA 1952-1954				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VETERINARIAN				16b. KIND OF BUSINESS/INDUSTRY VETERINARY MEDICINE			
17. FATHER'S NAME (First, Middle, Last) CLAUDE FOX				18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL KYTE			
19a. INFORMANT'S NAME (Type/Print) JANE C. FOX				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.D. #1, BOX 53BA, CHURCH HILL, MD. 21623			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOUNT HOLLY CEMETERY 12/9			
20c. LOCATION — City or Town, State MOUNT HOLLY, N.J.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE M.E. Newnam C.F.S.P.			
22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC ADENOCARCINOMA OF SMALL BOWEL DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 7 MONTHS			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) DEC. 5, 1992			
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER William H. Wood Jr. MD				29c. LICENSE NUMBER D08715			
29d. DATE SIGNED (Month, Day, Year) DEC. 5, 1992				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM H. WOOD, JR., M.D. 506 IDLEWILD AVE., EASTON, MD. 21601			
31. DATE FILED (Month, Day, Year) DEC - 7 1992				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN LIVEZEY FIRTH SR.				2. DATE OF DEATH MONTH 12 DAY 17 YEAR 1992		3. TIME OF DEATH 11:00 PM	
4. SOCIAL SECURITY NUMBER 219-18-4996		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-5-1919	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) 29152 Howell Point Road		9b. CITY, TOWN OR LOCATION OF DEATH Trappe	
9c. COUNTY OF DEATH Talbot				10a. STATE Maryland		10b. COUNTY Talbot	
10c. CITY, TOWN OR LOCATION Trappe				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 29152 Howell Point Road	
10f. ZIP CODE 21673				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman				16b. KIND OF BUSINESS/INDUSTRY Hatchery equipment			
17. FATHER'S NAME (First, Middle, Last) Thomas Thompson Firth, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Caryl Rogers			
19a. INFORMANT'S NAME (Type/Print) Barbara N. Firth				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29152 Howell Pt. Road, Trappe, MD 21673			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory			
20c. LOCATION — City or Town, State Salisbury, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. E. Newnam C.F.S.P.			
22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD 21601				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arthrosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Kevin J. O'Keefe MD			
29c. LICENSE NUMBER D35259				29d. DATE SIGNED (Month, Day, Year) DEC 21 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kevin J. O'Keefe, M.D., 606 Dutchman's Lane, Easton, MD 21601							
31. DATE FILED (Month, Day, Year) DEC 21 1992				32. REGISTRAR'S SIGNATURE J. Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 states any injury, or other traumatic event, the medical examiner must be notified at once.

KEVIN J. O'KEEFE, MD

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOLA MAE BLADES FAIRBANK				2. DATE OF DEATH MONTH 12 DAY 13 YEAR 1992		3. TIME OF DEATH 12:15 PM	
4. SOCIAL SECURITY NUMBER 213-01-8384		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5 18 1908	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Maryland				10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Berlin	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER #1 Meadow Lane Gull Creek Retirement Community				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) CHARLES H. Blades				18. MOTHER'S NAME (First, Middle, Maiden Surname) "unknown"			
19a. INFORMANT'S NAME (Type/Print) Shirley F. Chance				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #17 Southeast Dukes Ave., Easton, MD 21601			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Spring Hill Cemetery		20c. LOCATION — City or Town, State 12-18 Easton, MD 21601			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN D. MERCER, CFSF				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Digoxin Toxicity DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Renal Insufficiency DUE TO (OR AS A CONSEQUENCE OF): Chronic Atrial Fibrillation Organic Brain Syndrome						Approximate Interval Between Onset and Death 1 week	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Atrial Fibrillation Organic Brain Syndrome						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James E. Martin, M.D.				29c. LICENSE NUMBER D30690		29d. DATE SIGNED (Month, Day, Year) 12/13/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.							
31. DATE FILED (Month, Day, Year) DEC 18 1992				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37252

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLOTTE LOUISE FILLER				2. DATE OF DEATH MONTH Dec. DAY 22 , YEAR 1992		3. TIME OF DEATH 5:21PM	
4. SOCIAL SECURITY NUMBER 218-32-8241		5. SEX <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09/21/36	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 12217 WOODSBORO PIKE		9b. CITY, TOWN OR LOCATION OF DEATH KEYMAR	
9c. COUNTY OF DEATH FREDERICK				10a. STATE MD		10b. COUNTY FREDERICK	
10c. CITY, TOWN OR LOCATION KEYMAR				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12217 WOODSBORO PIKE	
10f. ZIP CODE 21757				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		14. RACE — American Indian, Black, White, etc. WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) TEACH. AIDE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACH. AIDE		16b. KIND OF BUSINESS/INDUSTRY PUB. SCHOOL	
17. FATHER'S NAME (First, Middle, Last) R. RUSSELL BLACKSTEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET PUTMAN			
19a. INFORMANT'S NAME (Type/Print) KENNETH F. FILLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12217 WOODSBORO PIKE KEYMAR MD 21757			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HAUGH'S CEMETERY		20c. LOCATION — City or Town, State LADIESBURG, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine O. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS WOODSBORO, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Deep vein thrombosis DUE TO (OR AS A CONSEQUENCE OF): b. Extensive colon carcinoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 12-10
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D1462C		29d. DATE SIGNED (Month, Day, Year) 12/23/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. J. H. Hartzler, 501 W 9th St, Frederick MD 21701</i>							
31. DATE FILED (Month, Day, Year) DEC 28 92				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carl C. Geary				2. DATE OF DEATH MONTH 12 DAY 16 YEAR 92		3. TIME OF DEATH 7:10 P M	
4. SOCIAL SECURITY NUMBER 220-10-1414		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-25-12	
8. FACILITY NAME (If not institution, give street and number) Frostburg Hospital, Inc.				9b. CITY, TOWN OR LOCATION OF DEATH Frostburg		9c. COUNTY OF DEATH Allegany	
10a. STATE Md.				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Mt. Savage	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER Calla Hill (P.O. Box 396)				10f. ZIP CODE 21545		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 6+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver		16b. KIND OF BUSINESS/INDUSTRY Trucking Co.			
17. FATHER'S NAME (First, Middle, Last) Thomas A. Geary				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Roby			
19a. INFORMANT'S NAME (Type/Print) Tim L. Geary				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 171, Corriganville, Md. 21524			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Methodist Cemetery 12/19		20c. LOCATION — City or Town, State Mt. Savage, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John P. Horn				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home, Frostburg, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Obstructive lung pathology</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Cancer Prostate</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <u>Several days</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>acute Septicemia - acute liver sepsis</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFY (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER S.L. Sandhir M.D.				29c. LICENSE NUMBER D144 64		29d. DATE SIGNED (Month, Day, Year) 12/17/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.L. Sandhir, M.D., Frostburg Hospital, Frostburg, Md. 21532							
31. DATE FILED DEC 18 1992		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, other traumatic event, the medical examiner must be notified at once.

92 37254

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLEN CARDER						2. DATE OF DEATH MONTH DAY YEAR DEC 16 1992		3. TIME OF DEATH 5:00 P. M.		
4. SOCIAL SECURITY NUMBER 217-10-7578A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JUNE 6 1913		
8a. FACILITY NAME (If not institution, give street and number) 420 WALNUT STREET						9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND			9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT										
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 420 WALNUT STREET				10f. ZIP CODE 21502			10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MD. STATE ROAD DEPT.			16b. KIND OF BUSINESS/INDUSTRY LABORER			
17. FATHER'S NAME (First, Middle, Last) WILLIAM NEWTON CARDER						18. MOTHER'S NAME (First, Middle, Maiden Surname) MAMIE LAYMAN				
19a. INFORMANT'S NAME (Type/Print) WILLIAM CARDER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 WALNUT STREET CUMBERLAND, MARYLAND 21502						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET CEMETERY DEC 10 1992			20c. LOCATION — City or Town, State CUMBERLAND MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIO RESP. ARREST Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. SEVERE COPD. c. d. 										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Cardiomyopathy, stroke, failure Cachexia										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ranjith</i>				29c. LICENSE NUMBER D19318			29d. DATE SIGNED (Month, Day, Year) DEC 17 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR N. RANJITHAN 517 OLDTOWN ROAD CUMBERLAND, MARYLAND 21502										
31. DATE FILED (Month, Day, Year) DEC 17 1992				32. REGISTRAR'S SIGNATURE <i>John A. Davidson</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows an injury or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Lee Gilpin				2. DATE OF DEATH MONTH 12 DAY 15 YEAR 92		3. TIME OF DEATH 6:30PM M	
4. SOCIAL SECURITY NUMBER 218-16-4960		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-13-1924 MD	
8a. FACILITY NAME (If not Institution, give street and number) 215 Penn. Ave				8b. CITY, TOWN OR LOCATION OF DEATH Cumberland		8c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 215 Penn Ave				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) WW II				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) retired Lt.		16b. KIND OF BUSINESS/INDUSTRY Police	
17. FATHER'S NAME (First, Middle, Last) Okey W. Gilpin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen V. Gilpin			
19a. INFORMANT'S NAME (Type/Print) Mr. William O. Gilpin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park		DATE 12-19		20c. LOCATION — City or Town, State Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the posterior pharynx with complications DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. mild hypertension						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i> Dpty Med Ex				29c. LICENSE NUMBER D 09157		29d. DATE SIGNED (Month, Day, Year) 12/15/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w 3rd st Cumb MD 21502							
31. DATE FILED (Month, Day, Year) DEC 17 1992				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED G. GOLD				2. DATE OF DEATH MONTH 12 DAY 11 YEAR 92		3. TIME OF DEATH 10:45 P	
4. SOCIAL SECURITY NUMBER 122-24-0020		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-26-1906	
9a. FACILITY NAME (If not institution, give street and number) Cumberland Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE MD				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 119 Elder Street			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) former secretary		16b. KIND OF BUSINESS/INDUSTRY manufacturing			
17. FATHER'S NAME (First, Middle, Last) Oliver Z. Noland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Whisner			
19a. INFORMANT'S NAME (Type/Print) Mrs. Virginia S. Carr				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Mary Street Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 12-16		20c. LOCATION — City or Town, State LaVale, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHF Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OB						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Rekynsalun				29c. LICENSE NUMBER DO4981		29d. DATE SIGNED (Month, Day, Year) 12/13/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER HALMOS 302 SCHLEYST Cumberland, Md 21502							
31. DATE FILED (Month, Day, Year) DEC 15 1992				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodwell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37257

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Louise Greiner						2. DATE OF DEATH MONTH DAY YEAR Dec. 25 1992		3. TIME OF DEATH 10:51 am M	
4. SOCIAL SECURITY NUMBER 216-10-3556		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 03 04 1907		8. BIRTHPLACE (State or Foreign Country) Oregon	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital at Easton, Md.						9b. CITY, TOWN OR LOCATION OF DEATH Easton		9c. COUNTY OF DEATH Talbot	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Queen Anne			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 13510 Main Street					10f. ZIP CODE 21657		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Caucasian		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 yrs. College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Post Mistress		16b. KIND OF BUSINESS/INDUSTRY Post Office			
17. FATHER'S NAME (First, Middle, Last) Joseph Greiner					18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Brill				
19a. INFORMANT'S NAME (Type/Print) Charles H. Greiner					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 326, Queen Anne, Maryland 21657				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery 12/30			20c. LOCATION — City or Town, State Hillsboro, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Moore Funeral Home</i>					22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardiopulmonary arrest									12-22-92
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Uncertain
a. Sick sinus node syndrome									
b. Due to (OR AS A CONSEQUENCE OF):									
c. Due to (OR AS A CONSEQUENCE OF):									
d. Due to (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Irreversible cerebral and brain stem ischemia									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Robert W. Trever, M.D.						29c. LICENSE NUMBER D10938		29d. DATE SIGNED (Month, Day, Year) 12-26-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7646 Ocean Gateway, Easton, Md. 21601									
31. DATE FILED (Month, Day, Year) DEC 29 '92				32. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

92 37258

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Josephine M. Hutson				2. DATE OF DEATH MONTH DAY YEAR 12 14 92		3. TIME OF DEATH 2:40 A M	
4. SOCIAL SECURITY NUMBER 215-20-6089		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-29-1921	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 135 N. Mechanic St Apt. 507				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Levi Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laverna Shamlin			
19a. INFORMANT'S NAME (Type/Print) Mr. Michael L. Hutson, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Rocky Gap VA Cem. 12-16		20c. LOCATION — City or Town, State Flintstone, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jones F Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anterior M.I. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 5 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William Lamm M.D.				29c. LICENSE NUMBER D 25406		29d. DATE SIGNED (Month, Day, Year) 12-18-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Lamm, M.D., 47 Virginia Ave., Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 21 1992				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37259

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY JEWEL HIDEY				2. DATE OF DEATH MONTH DAY YEAR 12-12-92		3. TIME OF DEATH 10:40 A.	
4. SOCIAL SECURITY NUMBER 216-14-1169		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-19-1923	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) 29 New Hampshire Avenue		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MD		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 29 New Hampshire Avenue	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: white				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) educator				16b. KIND OF BUSINESS/INDUSTRY College			
17. FATHER'S NAME (First, Middle, Last) John William Burns				18. MOTHER'S NAME (First, Middle, Maiden Surname) M. Catherine Evans			
19a. INFORMANT'S NAME (Type/Print) Mr. John Robert Hidey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Davis Memorial Cemetery 12-15			
20c. LOCATION — City or Town, State Cumberland, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli			
22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HYPERTENSIVE CARDIOVASCULAR HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. DPTV MED EX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER DPTV MED EX			
29c. LICENSE NUMBER D90157				29d. DATE SIGNED (Month, Day, Year) 12/12/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL SNOW, DPTV MED EX, 124 W THIRD STREET, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 16 1992				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodale			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified once.

2011-12-12

11/11

2011-12-12 SEP 11 11:11

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Flora A. Hoopengardner				2. DATE OF DEATH MONTH 12 DAY 11 YEAR 92		3. TIME OF DEATH 12:20 am	
4. SOCIAL SECURITY NUMBER 216-74-7755		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		5. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-22-1917	
9a. FACILITY NAME (If not institution, give street and number) Lions Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE PA		10b. COUNTY Bedford		10c. CITY, TOWN OR LOCATION Clearville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Route 3 Box 54				10f. ZIP CODE 15535		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		15b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Richard Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Melinda Miller			
19a. INFORMANT'S NAME (Type/Print) Mrs. Helen Self				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 204 Flintstone, MD 21530			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fellowship Cemetery 12-15		20c. LOCATION — City or Town, State Centerville, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James Z. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Severe C.O.P.D. c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C.H.F., Atrial fibrillation, Severe Anemia, reflux esophagitis.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER V.A. Ranjithan				29c. LICENSE NUMBER D19750		29d. DATE SIGNED (Month, Day, Year) 12-12-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V.A. Ranjithan, M.D., Lions Manor Nursing Home Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 15 1992				32. REGISTRAR'S SIGNATURE J. A. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be filled out by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37261

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Raymond Holden				2. DATE OF DEATH MONTH DAY YEAR 12 20 92		3. TIME OF DEATH 12:05 p m	
4. SOCIAL SECURITY NUMBER 220-01-9359		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 24 15	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Rt. 1 Box 470A		9b. CITY, TOWN OR LOCATION OF DEATH Greensboro		9c. COUNTY OF DEATH Caroline	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Caroline		10c. CITY, TOWN OR LOCATION Greensboro		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt. 1 Box 470A				10f. ZIP CODE 21639		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Grain			
17. FATHER'S NAME (First, Middle, Last) Medford Brown Holden				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Thompson Holden			
19a. INFORMANT'S NAME (Type/Print) S. Elizabeth Holden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Box 470A Greensboro, MD 21639			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro Cemetery		DATE 12-23		20c. LOCATION — City or Town, State Greensboro, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home Greensboro Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>PROSTATE CANCER</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 24RS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D01225		29d. DATE SIGNED (Month, Day, Year) 12-21-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen P. Carney 509 Idw. 1st Ave Easton 21601							
31. DATE FILED (Month, Day, Year) DEC 21 '92		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11

92 37262

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ITA HUBER				2. DATE OF DEATH MONTH 12 DAY 7 YEAR 1992		3. TIME OF DEATH 10:10PM	
4. SOCIAL SECURITY NUMBER 142-05-2909		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3 19 1907	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Meridian-The Pines		9b. CITY, TOWN OR LOCATION OF DEATH Easton	
9c. COUNTY OF DEATH Talbot				10a. STATE Maryland		10b. COUNTY Talbot	
10c. CITY, TOWN OR LOCATION Cordova				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11648 Kitty's Corner Road	
10f. ZIP CODE 21625				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Arthur Bizzarri				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madeline Zenorini			
19a. INFORMANT'S NAME (Type/Print) Rudolph Huber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11648 Kitty's Corner Rd., Cordova, MD 21625			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory 12-11 Salisbury, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Keith Phipps, CFSP				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Emaciation DUE TO (OR AS A CONSEQUENCE OF): Dementia DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death Min. month years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsons Depression						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER E. H. Webb				29c. LICENSE NUMBER D10966		29d. DATE SIGNED (Month, Day, Year) 12/9/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann H. Webb, M.D., 607 Dutchman's Lane, Easton, MD 21601							
31. DATE FILED (Month, Day, Year) DEC 9 1992				32. REGISTRAR'S SIGNATURE J. Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 is marked, the medical examiner must be notified at once.

Box 12714

1912-1913

92 37263

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES HILL				2. DATE OF DEATH MONTH 12 DAY 14 YEAR 92		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-34-5740		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-9-38	
8. FACILITY NAME (If not institution, give street and number) 321 MELVINS AVE.				9a. CITY, TOWN OR LOCATION OF DEATH GRASONVILLE		9c. COUNTY OF DEATH QUEEN ANNES	
10a. STATE MD.				10b. COUNTY QUEEN ANNES		10c. CITY, TOWN OR LOCATION GRASONVILLE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 321 MELVINS AVE.			
10f. ZIP CODE 21638				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 8+) College (1-4 or 8+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PATIENT HOME CARE		16b. KIND OF BUSINESS/INDUSTRY NURSING	
17. FATHER'S NAME (First, Middle, Last) ROY WILLIAMS				18. MOTHER'S NAME (First, Middle, Maiden Surname) AGNES SCOTT			
19a. INFORMANT'S NAME (Type/Print) GRETTE BOYKINS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 46, GRASONVILLE, MD. 21638			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHESTERFIELD CEMETERY 12-19-92 CENTREVILLE, MD.		20c. LOCATION — City or Town, State		20d. DATE 12-19-92	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Troy Dean</i>				22. NAME AND ADDRESS OF FACILITY BENNIE SMITH FUNERAL SERV. 426 DOVER STREET, EASTON, MD. 21601			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Pancreatic Cancer DUE TO (OR AS A CONSEQUENCE OF): a. Metastatic Pancreatic Cancer b. c. d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 6m	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D42816		29d. DATE SIGNED (Month, Day, Year) 12/18/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Richard A. Burgoyne 607 Dutchmans Lane Easton, MD 21601							
31. DATE FILED (Month, Day, Year) DEC 18 1992				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO.

DHMH-18 Rev 1/89

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1961127 UNIT # 06-64-45
HEFFNER, ALDEN A ELIZABETH
CCU-06 SEVILLA, MANUEL
06/29/1923 F 1292/37265

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALDEN A ELIZABETH HEFFNER				2. DATE OF DEATH MONTH DAY YEAR Dec. 20, 1992		3. TIME OF DEATH 1:16PM							
4. SOCIAL SECURITY NUMBER 216-14-6982		5. SEX <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06/29/23		8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA					
9a. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY GENERAL HOSP.				9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER				9c. COUNTY OF DEATH CARROLL					
RESIDENCE OF DECEDENT													
10a. STATE MD		10b. COUNTY CARROLL		10c. CITY, TOWN OR LOCATION NEW WINDSOR			10d. INSIDE CITY UNITS? <input type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 2201 NEW WINDSOR RD.				10f. ZIP CODE 21776		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SEAMSTRESS		15b. KIND OF BUSINESS/INDUSTRY SEW. FACTORY									
17. FATHER'S NAME (First, Middle, Last) MILLARD I. ENGLE				18. MOTHER'S NAME (First, Middle, Maiden Surname) ZENORA HAWK									
19a. INFORMANT'S NAME (Type/Print) PAUL HEFFNER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 NEW WINDSOR RD. NEW WINDSOR MD 21776									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTMINSTER CEMETERY 12/23		20c. LOCATION — City or Town, State WESTMINSTER, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine D. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS NEW WINDSOR, MD									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>SEPTICEMIA RESPIRATORY FAILURE</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <i>COPD</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>SEPTICEMIA</i> <i>D.I.C.</i>								Approximate interval Between Onset and Death					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. J. Seville MD</i>		29c. LICENSE NUMBER <i>07809</i>		29d. DATE SIGNED (Month, Day, Year) <i>12-22-92</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MANUEL J. SEVILLA 611 NUNN RD. WESTMINSTER</i>								31. DATE FILED (Month, Day, Year) <i>DEC 28 '92</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



92 37266

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLIAN MAY JONES				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 21, 1992		3. TIME OF DEATH 5:15 P M	
4. SOCIAL SECURITY NUMBER 215-26-3794		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 11, 1918	
9a. FACILITY NAME (If not Institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LA PLATA		9c. COUNTY OF DEATH CHARLES	
10a. STATE Maryland				10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Waldorf	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 50 Tadcaster Circle		10f. ZIP CODE 20602	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) —	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Home		17. FATHER'S NAME (First, Middle, Last) Harry I. Mahon, Sr.	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Pearce				19a. INFORMANT'S NAME (Type/Print) Joseph R. Jones, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16501 Baden-Westwood Rd., Brandywine, Md. 20613	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Silverbrook Ch. Cemetery		20c. LOCATION — City or Town, State Lorton, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark Brohawn MO0053				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Congestive Heart Failure</i>							
b. <i>Diabetes Mellitus</i>							
c. <i>Due to (OR AS A CONSEQUENCE OF):</i>							
d. <i>Due to (OR AS A CONSEQUENCE OF):</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Mark A. Zealks				29c. LICENSE NUMBER D-21031		29d. DATE SIGNED (Month, Day, Year) 12/22/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Leatherwood, MD				Waldorf Medical Park, P. O. Box 249, Waldorf, Maryland 20604			
31. DATE FILED (Month, Day, Year) DEC 24 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for or to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or under traumatic event, the medical examiner must be notified at once.

92 37267

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Barry K Jenkins				2. DATE OF DEATH MONTH DAY YEAR December 4 1992		3. TIME OF DEATH 2:00P.M. M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 31, 1959	
8. BIRTHPLACE (State or Foreign Country)				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital at Easton		9b. CITY, TOWN OR LOCATION OF DEATH Easton	
9c. COUNTY OF DEATH Talbot				10a. STATE Md.		10b. COUNTY Talbot	
10c. CITY, TOWN OR LOCATION Easton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES		10e. STREET AND NUMBER 25 Higgins St.	
10f. ZIP CODE 21601				10g. CITIZEN OF WHAT COUNTRY? us		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. 32K	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Herman Jenkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen			
19a. INFORMANT'S NAME (Type, Print) Ellen Jenkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Higgins St Easton 21601			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Richardson Memorial 12/15		20c. LOCATION — City or Town, State Easton	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Eric L. Dashiell ES				22. NAME AND ADDRESS OF FACILITY 382 East Ave. 21601			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous Cell Carcinoma Tonsil APRIL 1992 DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTASES							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER C.W. BAIN MD				29c. LICENSE NUMBER D00250		29d. DATE SIGNED (Month, Day, Year) 12/4/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.W. BAIN, 415 E. DAVENPORT, EASTON, MD, 21601							
31. DATE FILED (Month, Day, Year) DEC - 7 1992				32. REGISTRAR'S SIGNATURE Charles Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37268

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE G. Jones				2. DATE OF DEATH MONTH 12 DAY 22 YEAR 92		3. TIME OF DEATH 10:29 P.M.	
4. SOCIAL SECURITY NUMBER 227-52-7607		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-19-37	
8a. FACILITY NAME (If not institution, give street and number) FRANCES SCOTT KEY MED. CTR.				8b. CITY, TOWN OR LOCATION OF DEATH DUNDALK, MD.		8c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4810 Laurel Ave.				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lab Technician		16b. KIND OF BUSINESS/INDUSTRY Hospital			
17. FATHER'S NAME (First, Middle, Last) Sam Jackson				18. MOTHER'S NAME (First, Middle, Last) Lottie Chambers			
19a. INFORMANT'S NAME (Type/Print) David Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4810 Laurel Ave. Balt. MD. 21215			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Spreading Oak Bur. Ch. Cem. 12/27/92		20c. LOCATION — City or Town, State Buckingham Co. VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dandra V. Johnson				22. NAME AND ADDRESS OF FACILITY Reid's Funeral Home, Dillwyn, VA.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → exsanguinating bleed							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST thrombocytopenia							
DUE TO (OR AS A CONSEQUENCE OF):							
sepsis							
DUE TO (OR AS A CONSEQUENCE OF):							
perforated ulcer							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. B. Cal Jones				29c. LICENSE NUMBER AJ4147357APN		29d. DATE SIGNED (Month, Day, Year) 10/22/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. B. Cal Jones, Bk Sk Surgery Department Eastern Avenue 21224							
31. DATE FILED (Month, Day, Year) JAN 04 1993		32. REGISTRAR'S SIGNATURE Jana Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37269

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EARLE OLIVER KEYSER				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 18, 1992				3. TIME OF DEATH 10:50 A.	
4. SOCIAL SECURITY NUMBER 705071557		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 11 1900		8. BIRTHPLACE (State or Foreign Country) PENNA.	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 635 HILLTOP DRVIE				10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BALTIMORE & OHIO RAILROAD				16b. KIND OF BUSINESS/INDUSTRY ENGINEER	
17. FATHER'S NAME (First, Middle, Last) HUGH KEYSER				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH (UNKNOWN)					
19a. INFORMANT'S NAME (Type/Print) JOAN VALENTINE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#1 BOX# 86A LITTLE ORLEANS, MARYLAND 21766					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DAVIS MEM. METH. CEMETERY DEC 21, 1992 CUMBERLAND MD.				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Endstage Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Myocardopathy DUE TO (OR AS A CONSEQUENCE OF): c. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure Severe Chronic Lung disease Hypothyroidism								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary L. Wagoner, M.D.</i>				29c. LICENSE NUMBER D22181				29d. DATE SIGNED (Month, Day, Year) 12-20-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARY L. WAGONER, M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD 21502									
31. DATE FILED (Month, Day, Year) DEC 21 1992				32. REGISTRAR'S SIGNATURE <i>Greta Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

O BOX 68760,

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37270

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD W. KOCH Sr.				2. DATE OF DEATH MONTH DAY YEAR December 13, 1992		3. TIME OF DEATH 1:10 p.m.	
4. SOCIAL SECURITY NUMBER 214-05-5942		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-28-1904 MD	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 220 Arch Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ret. machinist		16b. KIND OF BUSINESS/INDUSTRY Tire Co.			
17. FATHER'S NAME (First, Middle, Last) Edward Christian Koch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth H. Smith			
19a. INFORMANT'S NAME (Type/Print) Mrs. Alice J. Koch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Arch Street Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Sunset Memorial Park 12-17		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GI Bleed Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. CBS c. DDD d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OTI						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Vik Poonai				29c. LICENSE NUMBER D 36766		29d. DATE SIGNED (Month, Day, Year) 12-13-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vik Poonai, PO Box 338, Cumberland, Md. 21502							
31. DATE FILED (Month, Day, Year) DEC 18 1992				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed and completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

92 37271

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER WILLIAM KING				2. DATE OF DEATH MONTH DECEMBER DAY 16 YEAR 1992				3. TIME OF DEATH 05:50 A.M.	
4. SOCIAL SECURITY NUMBER 214 05 8639		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7. DATE OF BIRTH Month MARCH Day 26 Year 1905				8. BIRTHPLACE (State or Foreign Country) W.VA.					
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 429 COLUMBIA STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CELANESE CORP.				16b. KIND OF BUSINESS/INDUSTRY SILK MANUF.	
17. FATHER'S NAME (First, Middle, Last) HENRY HARRISON KING				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA RACHEL DUNN					
19a. INFORMANT'S NAME (Type/Print) DELICIE DREW				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 TAMPLEY AVE. CUMBERLAND, MARYLAND 21502					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) HILLCREST CEMETERY DEC 19 1992				20c. LOCATION — City or Town, State CUMBERLAND MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Heart failure - Congestive</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Arteriosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <i>days</i> <i>years</i> <i>years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal failure</i> <i>rib fractures</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Colleen</i>				29c. LICENSE NUMBER D33417				29d. DATE SIGNED (Month, Day, Year) 12/16/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES R. MOEN, M.D. 1068 NATIONAL HWY-KCNR LA VALL, MO 21502									
31. DATE FILED (Month, Day, Year) DEC 17 1992				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 800 BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37272

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Audrey BARBARA Keys				2. DATE OF DEATH MONTH DAY YEAR Dec. 18, 1992		3. TIME OF DEATH 10:32 A. M	
4. SOCIAL SECURITY NUMBER 218-24-6423		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 17, 1929	
9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH LaPlata		9c. COUNTY OF DEATH Charles	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY CHARLES		10c. CITY, TOWN OR LOCATION IRONSIDES		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. BOX #157				10f. ZIP CODE 20643		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH GRADE College (1-4 or 5+) NONE		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		15b. KIND OF BUSINESS/INDUSTRY PRIVATE			
17. FATHER'S NAME (First, Middle, Last) JOSEPH HERBERT KEYS				16. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN CELESTINE WARD KEYS			
19a. INFORMANT'S NAME (Type/Print) JUDY BOWENS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #3 CHESAPEAKE PLACE, KING GEORGE, VIRGINIA 22485			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. HOPE CHURCH CEMETERY		20c. LOCATION — City or Town, State IRONSIDES, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Aurelio C. Thornton Johnson</i> AURELIO C. THORNTON JOHNSON				22. NAME AND ADDRESS OF FACILITY THORNTON'S FUNERAL HOME, POMONKEY, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>CARDIAC ARRHYTHMIA</u> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death 9 Hours	
		b. <u>Secondary Heart Block</u> DUE TO (OR AS A CONSEQUENCE OF):				3 DAYS	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF):				for years	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. <u>ADVANCED CANCER OF THE BREAST</u> <u>DIABETES MELLITUS</u> <u>ANEMIA</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Aurelio C. DeLaPaz, M.D.</i>				29c. LICENSE NUMBER D-16160		29d. DATE SIGNED (Month, Day, Year) 12-18-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Aurelio C. DeLaPaz, M.D., P. O. Box 120, LaPlata, Maryland 20646							
31. DATE FILED (Month, Day, Year) DEC 24 '92		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital for medical records. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37273

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>David B. Knight</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>06</i> YEAR <i>92</i>		3. TIME OF DEATH <i>M</i>	
4. SOCIAL SECURITY NUMBER <i>266-80-4989</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>43</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>05/31/49</i>	
8. BIRTHPLACE (State or Foreign Country) <i>PA</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Dorchester General Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge, Md.</i>	
9c. COUNTY OF DEATH <i>Dorchester</i>				10a. STATE <i>Md.</i>		10b. COUNTY <i>Dorchester</i>	
10c. CITY, TOWN OR LOCATION <i>Cambridge</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>213 Choptank Ave.</i>	
10f. ZIP CODE <i>21613</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>11th</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laborer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Factory Work</i>			
17. FATHER'S NAME (First, Middle, Last) <i>David Dukes</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Lee Jones</i>			
19a. INFORMANT'S NAME (Typed/Print) <i>Pat Finley-DCDSS</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 217 Cambridge, Md. 21613</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Capital Crematory 4/11/98</i>			
20c. LOCATION — City or Town, State <i>Dover, De.</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bennie Smith Services</i>			
22. NAME AND ADDRESS OF FACILITY <i>516 So. Main St. Harlock, Md. 21643</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cryptococcal meningitis and septicemia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Cryptococcal meningitis & septicemia</i> b. <i>AIDS - End stage</i> c. <i>Eosinophilic pustular folliculitis</i> d. <i>AIDS (demented)</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>12/7/92</i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Judy Washington, MD</i>				29c. LICENSE NUMBER <i>D31108</i>			
29d. DATE SIGNED (Month/Day/Year) <i>12/7/92</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Judy Washington, M.D., 408 Byrn Street, Cambridge, MD 21613</i>			
31. DATE FILED (Month, Day, Year) <i>DEC 15, 1992</i>				32. REGISTRAR'S SIGNATURE <i>Judi Benham-Rubio</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/96

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The undersigned that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Board of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked or item 23 has any ink, or other traumatic event, the medical examiner must be notified at once.

88 14470

SECRET

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92 37275

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL LEON LOHR				2. DATE OF DEATH MONTH 12 DAY 22 YEAR 92		3. TIME OF DEATH 5:28 AM	
4. SOCIAL SECURITY NUMBER 218-76-4485		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCTOBER 19 1956	
8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) 404 COLUMBIA AVE				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 404 COLUMBIA STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16b. KIND OF BUSINESS/INDUSTRY REST/BAR COOK			
17. FATHER'S NAME (First, Middle, Last) WILLIAM H. LOHR				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA SUE DORSEY			
19a. INFORMANT'S NAME (Type/Print) WILLIAM H. LOHR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11801 BAYBERRY AVE. S.W. POTOMAC PARK CUMBERLAND MD.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLCREST CEMETERY DEC 28 1992		20c. LOCATION — City or Town, State CUMBERLAND, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple stab and cutting wounds DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12-22-1992		28b. TIME OF INJURY 3:00AM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT CUT AND STABBED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 404 COLUMBIA AVE			
29a. CERTIFIER (Check only) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Laron J. Locke M.D.</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12-23-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LARON J. LOCKE M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) DEC 24 1992		32. REGISTRAR'S SIGNATURE <i>John Davidson Rodella</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000-1000-1000 1000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		92 37276	
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH		3. TIME OF DEATH	
EDITH V. LOAR		12 16 92		3:05 PM	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)	
216 225280		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		85 YRS.	
7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)		9. COUNTY OF DEATH	
9/16/17		MARYLAND		BALTIMORE COUNTY	
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
GOOD SAMARITAN HOSPITAL		BALTIMORE		BALTIMORE COUNTY	
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION	
MARYLAND		ALLEGANY		CUMBERLAND	
10d. INSIDE CITY LIMITS?		10e. STREET AND NUMBER		10f. ZIP CODE	
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		101 SPRINGDALE STREET		21502	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		HOME CARE NURSE		HEALTH	
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)		19. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
RICHARD HOWARD HOVERMILL		SUSAN ESTHER CLOSE		80 WRIGHT STREET FROSTBURG, MD 21532	
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		HILLCREST BURIAL PARK 12/20 CUMBERLAND, MD		MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
Douglas A. Hafer		HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502		Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):			
		c. DUE TO (OR AS A CONSEQUENCE OF):			
		d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)		27. MANNER OF DEATH	
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?	
		M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		JOSHI (INTERM)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE	
DR VIRENDRA JOSHI GOOD SAMARITAN HOSPITAL BALTIMORE, MD.		DEC 18 1992		Julia Davidson-Randall	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any trauma or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37277

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM ISAAC MAUZY				2. DATE OF DEATH MONTH DAY YEAR December 23, 1992		3. TIME OF DEATH 4:45 A M			
4. SOCIAL SECURITY NUMBER 216-05-1177		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 24 1906		8. BIRTHPLACE (State or Foreign Country) W. VA.	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland			9c. COUNTY OF DEATH Allegany		
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION FLINTSTONE			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER RFD#1 BOX#223C				10f. ZIP CODE 21530		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WILSON & PUGH CO.		16b. KIND OF BUSINESS/INDUSTRY WHOLESALE/RETAIL HARDWARE					
17. FATHER'S NAME (First, Middle, Last) SAUL P. MAUZY				18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTRUDE MALLOW					
19a. INFORMANT'S NAME (Type/Print) SADIE MAUZY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#1 BOX#223C FLINTSTONE, MARYLAND 21530					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) I.O.O.F. CEMETERY DEC 26 1992		DATE DEC 26 1992		20c. LOCATION — City or Town, State FLINTSTONE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Diabetes mel. a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF A-fib						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. H.C. Merrick				29c. LICENSE NUMBER D 28910		29d. DATE SIGNED (Month, Day, Year) 12/23/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. H.C. Merrick Memorial Hospital Medical Bldg. Cumberland, MD 21502									
31. DATE FILED (Month, Day, Year) DEC 24 1992		32. REGISTRAR'S SIGNATURE Julia Davidson							

1895

92 37278

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARSHALL JOSEPH MCKENZIE				2. DATE OF DEATH MONTH 12 DAY 23 YEAR 92				3. TIME OF DEATH 0140 A M			
4. SOCIAL SECURITY NUMBER 214059761				5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01 22 06		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND			10b. COUNTY ALLEGANY			10c. CITY, TOWN OR LOCATION CUMBERLAND			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
10e. STREET AND NUMBER ROUTE 6, BOX 236						10f. ZIP CODE 21502			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WW II			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 8+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian				16b. KIND OF BUSINESS/INDUSTRY Rubber Tire			
17. FATHER'S NAME (First, Middle, Last) Thomas L. McKenzie						18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Warne					
19a. INFORMANT'S NAME (Type/Print) Mrs. Emma McKenzie						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 6, Box 236, Cumberland, MD 21502					
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park 26th Cumberland, MD				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Hafer</i>						22. NAME AND ADDRESS OF FACILITY Hafer Chapel of the Hills Mortuary 1302 Nat'l. Hwy., LaVale, MD 21502					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arrhythmia											
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas E. Chappell</i>						29c. LICENSE NUMBER MD 35135		29d. DATE SIGNED (Month, Day, Year) 12/23/92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. THOMAS CHAPPELL, M.D., B.M.G., 912 SETON DRIVE, CUMBERLAND, MD 21502											
31. DATE FILED (Month, Day, Year) DEC 23 1992				32. REGISTRAR'S SIGNATURE <i>J. Davidson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any other traumatic event, the medical examiner must be notified at once.

DEC 2 1933

DEC 2 1933

92 37279

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH MILLER				2. DATE OF DEATH MONTH 12 DAY 15 YEAR 1992				3. TIME OF DEATH 20:06 P M			
4. SOCIAL SECURITY NUMBER 213 01 5945		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-2-1913		8. BIRTHPLACE (State or Foreign Country) Md.			
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MARYLAND				9c. COUNTY OF DEATH ALLEGANY			
10a. STATE Md.				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Frostburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER Rt. 1, Box 200				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		15b. KIND OF BUSINESS/INDUSTRY Pajama Co.							
17. FATHER'S NAME (First, Middle, Last) Richard Wilson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Adams							
19a. INFORMANT'S NAME (Type/Print) Richard N. Wilson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13402 Pershing St., Cumberland, Md. 21502							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Memorial Park		DATE 12/18		20c. LOCATION — City or Town, State Frostburg, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Horn</i>				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home, Frostburg, Md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Renal Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Acute GI Bleeding and Shock Acute Myocardial Infarction								Approximate Interval Between Onset and Death 24 hours 24 hours 5 days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial infarction Peptic ulcer 2nd to chronic A. occlusion								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chapman H. M.D.</i>				29c. LICENSE NUMBER 224951		29d. DATE SIGNED (Month, Day, Year) Dec 16, 92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHAPMAN H. M.D. 417 PARK TERRACE, FROSTBURG, MD 21532											
31. DATE FILED (Month, Day, Year) DEC 18 1992				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on this death certificate is to be used for the purpose of recording the death and for the purpose of determining the cause of death. It is to be filled out by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 33 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37280

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLORIA ELLEN MACKERETH				2. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1992				3. TIME OF DEATH 02:30 AM	
4. SOCIAL SECURITY NUMBER 216 22 6804		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-19-1928		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12107 Dandelion Ave. S.W.				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE -- American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker			16b. KIND OF BUSINESS/INDUSTRY own home		
17. FATHER'S NAME (First, Middle, Last) Jacob C. Moyers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth V. Miller					
19a. INFORMANT'S NAME (Type/Print) Mr. Chester W. Mackereth				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12107 Dandelion Avenue, S.W. Cumberland, MD 21502					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Davis Memorial Cemetery 12-18			20c. LOCATION -- City or Town, State Cumberland, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Oat Cell Carcinoma, Rt Lung DUE TO (OR AS A CONSEQUENCE OF): c. Pneumonia Rt Lung DUE TO (OR AS A CONSEQUENCE OF): d. Chronic Obstructive pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancytopenia 2°y to Chemotherapy								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER R. Fadl M.D.				29c. LICENSE NUMBER 16150			29d. DATE SIGNED (Month, Day, Year) 12.15.92		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RAGAA FADL, M.D., 921 SETON DRIVE, CUMBERLAND, MD 21502									
31. DATE FILED (Month, Day, Year) DEC 17 1992				32. REGISTRAR'S SIGNATURE Jane Davidson-Rendell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 92 37281

1. DECEDENT'S NAME (First, Middle, Last) WETZEL LEE MEADOWS				2. DATE OF DEATH MONTH 12 DAY 13 YEAR 92		3. TIME OF DEATH 0035 A M	
4. SOCIAL SECURITY NUMBER 235 62 2839		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 07 41	
8. BIRTHPLACE (State or Foreign Country) West Va.				9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 16 Queen City Pavement	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Asphalt Worker		16b. KIND OF BUSINESS/INDUSTRY Asphalt Company	
17. FATHER'S NAME (First, Middle, Last) Arnold Lee Meadows				18. MOTHER'S NAME (First, Middle, Maiden Surname) Verlie Waddell			
19a. INFORMANT'S NAME (Type/Print) Katherine Meadows				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 Monroe St. Annapolis, Md. 21403			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Mem. Gardens 12-14-92		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. R. De... Jr.				22. NAME AND ADDRESS OF FACILITY Leasure-Stein, Inc, 230 Baltimore Av. Cumberland, Md. 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS							
DUE TO (OR AS A CONSEQUENCE OF):							
b. HEPATO RENAL FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. ALCOHOLISM							
DUE TO (OR AS A CONSEQUENCE OF):							
d. ACUTE PANCREATITIS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 YES 2 NO				28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ashe				29c. LICENSE NUMBER DJ6907		29d. DATE SIGNED (Month, Day, Year) 12/13/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARJIT SIDHU, M.D. 925 BISHOP WALSH DRIVE CUMBERLAND, MD. 21502							
31. DATE FILED (Month, Day, Year) DEC 16 1992				32. REGISTRAR'S SIGNATURE J. Davidson-Randall			

1057-80

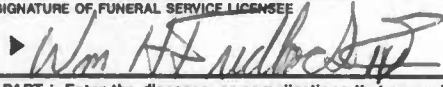
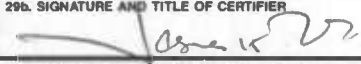
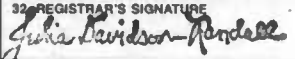
10

DEC 10 1964

92 37282

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Lucille G. Mertz				2. DATE OF DEATH MONTH DAY YEAR Dec. 13 1992		3. TIME OF DEATH 4:10 A.M.	
4. SOCIAL SECURITY NUMBER 214-36-6849		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 2, 1909 Md.	
9a. FACILITY NAME (If not institution, give street and number) Moran Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Westernport		9c. COUNTY OF DEATH Alleg.	
RESIDENCE OF DECEASED							
10a. STATE Md.		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Westernport		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 443 Walnut St.				10f. ZIP CODE 26726		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY -----			
17. FATHER'S NAME (First, Middle, Last) George Green				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary R. Dressman			
19a. INFORMANT'S NAME (Type/Print) James Mertz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 465 Spruce St. Westernport, Md. 21562			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Peter's Cemetery		20c. LOCATION — City or Town, State Westernport, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fredlock Funeral Home Piedmont, Wv.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. Ischemic Organic Brain Syndrome							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D21244		29d. DATE SIGNED (Month, Day, Year) 12/15/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jesus H. Tan, M.D., Frostburg Plaza, Frostburg, MD 21532							
31. DATE FILED (Month, Day, Year) DEC 16 1992		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37283

1. DECEDENT'S NAME (First, Middle, Last) FRANKLIN JOHN MCELWEE				2. DATE OF DEATH MONTH 12 DAY 12 YEAR 92		3. TIME OF DEATH 2345 P M					
4. SOCIAL SECURITY NUMBER 214 14 7976		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 24 19		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY			
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 230 Barton Blvd.				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) tread room		15b. KIND OF BUSINESS/INDUSTRY Tire Co.					
17. FATHER'S NAME (First, Middle, Last) John Franklin McElwee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Iva I. Lohr							
19a. INFORMANT'S NAME (Type/Print) Mr. John F. McElwee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Barton Blvd. Cumberland, MD 21502							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park		DATE 12-15		20c. LOCATION — City or Town, State Cumberland, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF): Acute anterior lateral myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death minutes hours days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Ellen M. O				29c. LICENSE NUMBER 033417		29d. DATE SIGNED (Month, Day, Year) 12/13/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES R. MOEN, M.D. 1068 NATIONAL HWY-RTOR LAVALLE, MD 21502											
31. DATE FILED (Month, Day, Year) DEC 15 1992				32. REGISTRAR'S SIGNATURE Jana Davidson-Randall							

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GERALD V. MILLER SR.				2. DATE OF DEATH MONTH DAY YEAR December 7, 1992		3. TIME OF DEATH 11:35 p.m.	
4. SOCIAL SECURITY NUMBER 217-10-1144		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-25-1918	
8. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 501 Baltimore Avenue				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) curing dept.		16b. KIND OF BUSINESS/INDUSTRY tire co.			
17. FATHER'S NAME (First, Middle, Last) Albert L. Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruby Barrick			
19a. INFORMANT'S NAME (Type/Print) Mrs. Leona V. Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Baltimore Avenue Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery 12-14		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James J. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Advanced Ca. Colon - mets to Lungs					
		b. Lungs Failure					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. Intractable Bacteremia					
		d. Deep venous Thrombosis					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D 23371		29d. DATE SIGNED (Month, Day, Year) 12/9/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Qamar Zaman, M.D., 625 Kent Ave., Cumberland, Md. 21502							
31. DATE FILED (Month, Day, Year) DEC 15 1992				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director must retain the certificate for 72 hours after death. If the death is not reported to the funeral director, the funeral director must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William E Marshall				2. DATE OF DEATH MONTH DAY YEAR 12 23 1992		3. TIME OF DEATH 1:45A M	
4. SOCIAL SECURITY NUMBER 213-16-7002		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 5 1904	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital at Easton		9b. CITY, TOWN OR LOCATION OF DEATH Easton	
9c. COUNTY OF DEATH Talbot				10a. STATE MD		10b. COUNTY Caroline	
10c. CITY, TOWN OR LOCATION Denton				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 280 Camp Road	
10f. ZIP CODE 21629				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) farmer			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) farmer				16b. KIND OF BUSINESS/INDUSTRY grain			
17. FATHER'S NAME (First, Middle, Last) Samuel Marshall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Abby A. Samonas Marshall			
19a. INFORMANT'S NAME (Type/Print) Virginia Mae Hudson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3 Box 516 Wyoming, Delaware 19934			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE Greensboro Cemetery 12-26 Greensboro MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mike C. Thiel</i>				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dehydration							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. Anorexia							
c. Altered mental status							
d. Pneumonia / Sepsis							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CLL Dementia							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Keeney</i>				29c. LICENSE NUMBER D42005			
29d. DATE SIGNED (Month, Day, Year) 12/23/92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 400 Melvin Ave Queenstown, MD 21601			
31. DATE FILED (Month, Day, Year) DEC 31 92				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARTHA ELIZABETH MacDONALD				2. DATE OF DEATH MONTH DAY YEAR 12-17-1992		3. TIME OF DEATH H M 4:05 PM		
4. SOCIAL SECURITY NUMBER 213-20-7255		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-31-1915		
8. BIRTHPLACE (State or Foreign Country) West. VA.				9a. FACILITY NAME (If not institution, give street and number) 51 Park Lane, Hyde Park		9b. CITY, TOWN OR LOCATION OF DEATH Easton		
9c. COUNTY OF DEATH Talbot				10a. STATE Maryland		10b. COUNTY Talbot		
10c. CITY, TOWN OR LOCATION Easton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 51 Park Lane		
10f. ZIP CODE 21601				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS XX <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse				16b. KIND OF BUSINESS/INDUSTRY Mercy Hospital				
17. FATHER'S NAME (First, Middle, Last) Homer Guy MacDonald				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wanda Carter				
19a. INFORMANT'S NAME (Type/Print) Catherine V. Hoover				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #51 Park Lane, Hyde Park, Easton, MD 21601				
20a. METHOD OF DISPOSITION XX <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 12-21 Woodlawn, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCERON CFSP				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD 21601				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Metastatic Squamous Cell Carcinoma 2 yrs Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD							Approximate interval Between Onset and Death Min 2 yrs	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 12-17-1992				
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER Ann H. Webb, M.D.				29c. LICENSE NUMBER D10966				
29d. DATE SIGNED (Month, Day, Year) 12-18-92				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann H. Webb, M.D., 607 Dutchman's Lane, Easton, MD 21601				
31. DATE FILED (Month, Day, Year) DEC 21 1992				32. REGISTRAR'S SIGNATURE John Davidson-Randall				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows an injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Norman Wesley Messick Jr.				2. DATE OF DEATH Dec. 9, 1992		3. TIME OF DEATH 10:25 P.M.	
4. SOCIAL SECURITY NUMBER 213-16-1158		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 15, 1920	
8. BIRTHPLACE (State or Foreign Country) Md.				9a. FACILITY NAME (If not institution, give street and number) 4417 Cloverdale Road		9b. CITY, TOWN OR LOCATION OF DEATH Hurlock,	
9c. COUNTY OF DEATH Dorchester				10a. STATE Md.		10b. COUNTY Dorchester	
10c. CITY, TOWN OR LOCATION Hurlock				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4417 Cloverdale Road	
10f. ZIP CODE 21643				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Farmer	
17. FATHER'S NAME (First, Middle, Last) Norman Wesley Messick Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Coulbourne			
19a. INFORMANT'S NAME (Type/Print) Norman Wesley Messick III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4417 Cloverdale Rd. Hurlock, Md. 21643			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory 10/10/92		20c. LOCATION — City or Town, State Dover, Del.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [Signature]				22. NAME AND ADDRESS OF FACILITY Williamson Funeral Home Federalsburg, Md. 21632			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure							
b. DUE TO (OR AS A CONSEQUENCE OF) congestive heart failure							
c. DUE TO (OR AS A CONSEQUENCE OF) coronary artery disease							
d. DUE TO (OR AS A CONSEQUENCE OF) atherosclerotic cardiovascular disease							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined							
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER HUBERT T. DAWKINS JR. M.D.				29c. LICENSE NUMBER D02824		29d. DATE SIGNED (Month, Day, Year) 12/10/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HUBERT T. DAWKINS JR. M.D. 508 DEWILD AVE EASTON, MARYLAND 21601							
31. DATE FILED (Month, Day, Year) DEC 10 1992				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes, possibly a list or description of items, including phrases like "one half", "one quarter", and "one eighth".

Handwritten text, possibly a date or a reference number.

Handwritten text, possibly a signature or a name, enclosed in parentheses.

Handwritten text, possibly a date or a reference number.

Handwritten text, possibly a small note or a mark.

92 37288

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry Preaut Megargee				2. DATE OF DEATH MONTH DAY YEAR 12 9 92		3. TIME OF DEATH EST 1404 M	
4. SOCIAL SECURITY NUMBER 156-01-1539		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 13, 1921	
9a. FACILITY NAME (If not institution, give street and number) Univ. of Md. Oncology				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City,		9c. COUNTY OF DEATH Baltimore City	
10a. STATE Maryland				10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Neavitt	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER -----			
10f. ZIP CODE 21652				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 7 Lawyer		17. KIND OF BUSINESS/INDUSTRY Legal			
17. FATHER'S NAME (First, Middle, Last) Henry P. Megargee Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bernice Shearer			
19a. INFORMANT'S NAME (Type/Print) Sarah Wells Megargee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neavitt, Maryland 21652			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory		20c. DATE 12/10		20d. LOCATION — City or Town, State Dover, De.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harrison E. Leonard				22. NAME AND ADDRESS OF FACILITY Harrison E. Leonard Funeral Home, 312 S. Talbot St., St. Michaels, Md. 21663			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTIC SHOCK DUE TO (OR AS A CONSEQUENCE OF): 24 HR Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. NEUTROPENIA DUE TO (OR AS A CONSEQUENCE OF): 3 DAYS c. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): 2 DAYS d. PROSTATE CANCER 13 YR							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ADRENAL INSUFFICIENCY DIABETES							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Carl Shanholzer MD				29c. LICENSE NUMBER Q38683		29d. DATE SIGNED (Month, Day, Year) DEC 09, 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CARL SHANHOLZER, M.D. UNIV OF MD CANCER CENTER 22 S. GREENE ST. BALTIMORE 4201							
31. DATE FILED (Month, Day, Year) DEC 11 1992				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37289

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BARTHOL MATHIAS (m.n. Eileen)				2. DATE OF DEATH MONTH 12 DAY 23 YEAR 92		3. TIME OF DEATH 6:00 ^A _M	
4. SOCIAL SECURITY NUMBER 216-05-3848		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 98 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-07-1894	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. FACILITY NAME (If not institution, give street and number) LONG VIEW NSG HOME		10. CITY, TOWN OR LOCATION OF DEATH MANCHESTER	
11. RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY CARROLL 10c. CITY, TOWN OR LOCATION MANCHESTER				12. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. COUNTY OF DEATH CARROLL	
14. STREET AND NUMBER 3332 MAIN STREET				15. ZIP CODE 21102		16. CITIZEN OF WHAT COUNTRY? USA	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: WHITE	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper/Companion		23. KIND OF BUSINESS/INDUSTRY Domestic			
24. FATHER'S NAME (First, Middle, Last) John Wesley Reaver, Sr.				25. MOTHER'S NAME (First, Middle, Maiden Surname) Addie Agnes Haifley			
26. INFORMANT'S NAME (Type/Print) Anna Ray Hunter				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Baldwin Park Drive, Westminster, MD 21157			
28. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. John (Leisters) Church Cemetery, Westminster, MD		30. LOCATION — City or Town, State Westminster, MD			
31. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert A. Myers				32. NAME AND ADDRESS OF FACILITY 91 WILKES STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Broncho Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. arteriosclerotic Cardio Vascular Disease							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
35. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		36. DATE OF INJURY (Month, Day, Year)		37. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		38. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		40. DESCRIBE NOW INJURY OCCURED					
41. LOCATION (Street and Number or Rural Route Number, City or Town, State)		42. DATE SIGNED (Month, Day, Year) 12/23/92					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W H Howard MD				29c. LICENSE NUMBER D02386		29d. DATE SIGNED (Month, Day, Year) 12/23/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W H Howard MD 3223 MAIN ST, MANCHESTER, MD 21102							
31. DATE FILED (Month, Day, Year) DEC 28 92		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7352-013

blh

92 37290

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Darren David Magruder				2. DATE OF DEATH MONTH DAY YEAR 12 24 1992		3. TIME OF DEATH 3:00 A.M.	
4. SOCIAL SECURITY NUMBER 217-98-1368		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 25 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/17/67	
9a. FACILITY NAME (If not institution, give street and number) Deer Park Road @ Jeffra's Court				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
10a. STATE MD				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Finksburg	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1571 Deer Park Road			
10f. ZIP CODE 21048				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) worker		16b. KIND OF BUSINESS/INDUSTRY subway			
17. FATHER'S NAME (First, Middle, Last) David Gray				18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara Lee Magruder			
19a. INFORMANT'S NAME (Type/Print) Barbara Magruder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5121 4th St. NE, Apt 305, Washington, DC 20011			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremations		20c. DATE 12/29		20d. LOCATION — City or Town, State Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert K. Pritts, Sr.				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Head Injuries Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12 24 1992		28b. TIME OF INJURY 2:15 A.M.		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Driver in auto/pole impact		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) on street					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Deer Park Rd. @ Jeffra's Ct.							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12 24 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) DEC 28 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37291

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James R. Piper				2. DATE OF DEATH MONTH - DAY - YEAR 12-15-1992		3. TIME OF DEATH 5:06 P.M.	
4. SOCIAL SECURITY NUMBER 218-12-5101		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-20-1923	
8a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Cumberland		8c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 16801 Dennis Road, S.E.				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) retired		16b. KIND OF BUSINESS/INDUSTRY CSX Corp.			
17. FATHER'S NAME (First, Middle, Last) James W. Piper				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Ralston			
19a. INFORMANT'S NAME (Type/Print) Mrs. Minnie M. Piper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16801 Dennis Road S.E. Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hartsock Cemetery		20c. DATE 12-18		20d. LOCATION — City or Town, State Oldtown, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC TAMPONADE DUE TO (OR AS A CONSEQUENCE OF): AORTIC VALVE REPLACEMENT Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 4 hours 2 weeks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C.A.D. IV. dys function							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William Lamm				29c. LICENSE NUMBER D 25406		29d. DATE SIGNED (Month, Day, Year) 12-16-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Lamm M.D., 47 Virginia Ave., Cumberland, MD 21502							
31. DATE FILED DEC 17 1992				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

July 11th 1856. To the Hon. Secy of War
Washington D.C.

1856
July 11th

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				92 37292			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) Sarah T. Peoples				2. DATE OF DEATH MONTH 12 DAY 12 YEAR 92				3. TIME OF DEATH 10:30 PM			
4. SOCIAL SECURITY NUMBER 073-16-8642A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 12, 1912		8. BIRTHPLACE (State or Foreign Country) Baltimore, Md.			
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton				9c. COUNTY OF DEATH Talbot			
10a. STATE Maryland				10b. COUNTY Caroline		10c. CITY, TOWN OR LOCATION Federalsburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER Rt. 1, Box 112				10f. ZIP CODE 21632		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Production operator		16b. KIND OF BUSINESS/INDUSTRY Maryland Plastics Co.							
17. FATHER'S NAME (First, Middle, Last) William Thomas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Green Thomas							
19a. INFORMANT'S NAME (Type/Print) Robert Peoples				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 112, Federalsburg, Md. 21632							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cem. 12/17/92		20c. LOCATION — City or Town, State Beulah, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶				22. NAME AND ADDRESS OF FACILITY 216 N. Main St. Md. Frampton-Hawkins-Eskow F. H. Federalsburg, 21632							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebrovascular Accident</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Seizure disorder</u> <u>Atrial Fibrillation</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER James Sides MD				29c. LICENSE NUMBER D 31376		29d. DATE SIGNED (Month, Day, Year) 12-14-92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Sides PO Box 496 Denton MD											
31. DATE FILED (Month, Day, Year) DEC 17 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

92 37293

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PHILIP R. PIERPONT				2. DATE OF DEATH MONTH 12 DAY 11 YEAR 1992		3. TIME OF DEATH 8:00 AM	
4. SOCIAL SECURITY NUMBER 219-07-4741		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH MONTH 11 DAY 17 YEAR 1914	
9a. FACILITY NAME (If not institution, give street and number) 5411 Windward Drive				9b. CITY, TOWN OR LOCATION OF DEATH Tilghman		9c. COUNTY OF DEATH Talbot	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Tilghman		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5411 Windward Drive				10f. ZIP CODE 21671		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 6+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Proprietor		16b. KIND OF BUSINESS/INDUSTRY Gas Station/Garage			
17. FATHER'S NAME (First, Middle, Last) Edwin Lowell Pierpont				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Celeste Zimmerman			
19a. INFORMANT'S NAME (Type/Print) Hellen S. Pierpont				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 Windward Drive, Tilghman, MD 21671			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Johns Cemetery		20c. LOCATION — City or Town, State 12-14 Tilghman, MD		20d. DATE 12-14	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN R. MERCERON CFSF				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Ca Prostate a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate interval Between Onset and Death 1yr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) _____ 28b. TIME OF INJURY _____ 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED _____ 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____ 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER DC 58174		29d. DATE SIGNED (Month, Day, Year) 12/11/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald T. Lewers, M.D., 506 Idlewild Avenue, Easton, MD 21601							
31. DATE FILED (Month, Day, Year) DEC 14 1992				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Mr. [illegible] [illegible]

X
F
X

12/1/1914

12/1/1914

92 37294

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ADOLPH PRETZLER				2. DATE OF DEATH MONTH DAY YEAR December 18 1992		3. TIME OF DEATH M 9:05 AM	
4. SOCIAL SECURITY NUMBER 218-30-0889		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 87		6. AGE (In yrs. last birthday) YRS. 87		7. DATE OF BIRTH (Month, Day, Year) 8-19-1905	
8. BIRTHPLACE (State or Foreign Country) Austria							
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital at Easton				9b. CITY, TOWN OR LOCATION OF DEATH Easton		9c. COUNTY OF DEATH Talbot	
10a. STATE Maryland				10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 9699 Copperville Rd.				10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) Estate Manager				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Josef Pretzler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Koren			
19a. INFORMANT'S NAME (Type/Print) Elselore H. Pretzler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 664, Easton, MD 21601			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory 12-22		20c. LOCATION — City or Town, State Salisbury, MD 21801			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. E. Newnam III C.F.S.P.				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary Arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Aortic Stenosis, Coronary Disease, Pneumonia years a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas W. Fauntleroy, Jr., M.D.				29c. LICENSE NUMBER D15315		29d. DATE SIGNED (Month, Day, Year) 12/18/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas W. Fauntleroy, Jr., M.D., 403 Marvel Court, Easton, MD 21601							
31. DATE FILED (Month, Day, Year) DEC 22 1992				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7270-011
B.K.S

92 37295

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY Marjorie				2. DATE OF DEATH MONTH 12 DAY 21 YEAR 92				3. TIME OF DEATH 1:45 P M	
4. SOCIAL SECURITY NUMBER 216-54-8958		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 13, 1949		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) ROUTE#313				9b. CITY, TOWN OR LOCATION OF DEATH Greensboro				9c. COUNTY OF DEATH CAROLINE	
10a. STATE MD		10b. COUNTY Caroline		10c. CITY, TOWN OR LOCATION Goldsboro				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER Box 8, Meeks Road				10f. ZIP CODE 21636				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) shipper				16b. KIND OF BUSINESS/INDUSTRY International Playtex	
17. FATHER'S NAME (First, Middle, Last) Ralph Corkell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Carter Corkell					
19a. INFORMANT'S NAME (Type/Print) Andrew C. Robinson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 8, Meeks Road Goldsboro, Md 21636					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, church, or other place) Capital Crematory				DATE 12-27		20c. LOCATION — City or Town, State Dover, Delaware	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> HIGHWAY							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 12-21-1992		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED DRIVER IN AUTO/AUTO IMPACT	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) MAJOR HIGHWAY				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ROUTE#313					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) 12-22-1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLUE, JR. MD 111 PENN STREET BALTIMORE, MARYLAND 21201									
31. DATE FILED (Month, Day, Year) DEC 28 '92				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37296

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Minnie P. Richard				2. DATE OF DEATH MONTH DAY YEAR 12 25 92		3. TIME OF DEATH 5:00 p m	
4. SOCIAL SECURITY NUMBER 222-16-4924		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 9, 09	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) P.O. Box 1		9b. CITY, TOWN OR LOCATION OF DEATH Henderson	
9c. COUNTY OF DEATH Caroline				10a. STATE MD		10b. COUNTY Caroline	
10c. CITY, TOWN OR LOCATION Henderson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER P.O. Box 1	
10f. ZIP CODE 21640				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 6+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) accounts receivable		16b. KIND OF BUSINESS/INDUSTRY International Corp Laytex	
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
19a. INFORMANT'S NAME (Type/Print) James Richard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1026 Dundee Florida 33837			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name, City or Town, State, Zip Code) Greensboro Cemetery 12-29		20c. LOCATION — City or Town, State Greensboro, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steph Therle</i>				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21630			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute infection</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Consecutive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Atherosclerotic Coronary Artery D.</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Degenerative Arthritis</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall</i>				29c. LICENSE NUMBER C1000724		29d. DATE SIGNED (Month, Day, Year) 12/30/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Davidson-Randall MD 725 S Queen St Baltimore							
31. DATE FILED (Month, Day, Year) 12/30/92 DEC 31 '92				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be attached to the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified once.

which is not
present in the same way
as the other is in the

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the first of the

92 37297

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Pearl Ruth Rowe</i>				2. DATE OF DEATH MONTH <i>12</i> DAY <i>27</i> YEAR <i>1992</i>		3. TIME OF DEATH <i>9:30 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>217181833</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 4, 1923</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Good Samaritan Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>City</i>				RESIDENCE OF DECEDENT			
10a. STATE <i>Md.</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Randallstown</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3601 Briarstone Rd.</i>				10f. ZIP CODE <i>21133</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Homemaking</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Franklin Fisher</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ruth Berlena Smith</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Rosella Taylor</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3511 Flannery Lane, Baltimore, Md. 21207</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metro Crematory, Inc. 12/27/92</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md.</i>		20d. DATE <i>12/27/92</i>	
21. SIGNATURE OF FORMAL SERVICE LICENSEE <i>H. J. Schlerdt</i>				22. NAME AND ADDRESS OF FACILITY <i>Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>metastatic cancer</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Non-Hodgkin Lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. K. Pitt Resident</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>12/27/1992</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Hamid R. Chimeh, Good Samaritan Hosp.; 5601 Loch Raven Blvd.; Baltimore, MD</i>							
31. DATE FILED (Month, Day, Year) <i>DEC 28 '92</i>		32. REGISTRAR'S SIGNATURE <i>John H. Anderson</i> 21239					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000

MS 502

92 37298

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Allan Lee Schaffer				2. DATE OF DEATH MONTH DAY YEAR 12/6/92		3. TIME OF DEATH 2 P M	
4. SOCIAL SECURITY NUMBER 217-05-0433		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/12/31	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Westernport		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Apt # 213 100 Grandview Drive				10f. ZIP CODE 21562		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coat Checker		16b. KIND OF BUSINESS/INDUSTRY Night Club			
17. FATHER'S NAME (First, Middle, Last) Kenneth E. Schaeffer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Genevieve E. Kerns			
19a. INFORMANT'S NAME (Type/Print) Genevieve Schaeffer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. # 213 100 Grandview Drive			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Philos Cemetery 12/9/92		20c. LOCATION — City or Town, State Westernport Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wayne Bal</i>				22. NAME AND ADDRESS OF FACILITY Boal-Warnick Funeral Home Westernport, Md. 21562			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>exacerbation of chronic obstructive lung disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>metastatic small cell cancer of the lung</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Sagin</i>				29c. LICENSE NUMBER D 35481		29d. DATE SIGNED (Month, Day, Year) 12/14/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Sagin M.D., Memorial Hospital, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 22 1992		32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

92 37299

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) IDA HARRIET SLOAN				2. DATE OF DEATH MONTH DAY YEAR December 16, 1992		3. TIME OF DEATH 6:58 A.M.	
4. SOCIAL SECURITY NUMBER 214-07-2836		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 21 1913 Maryland	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 17 VALLEY STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE KEEPER		15b. KIND OF BUSINESS/INDUSTRY HOUSE KEEPER			
17. FATHER'S NAME (First, Middle, Last) ROBERT LEE BLUBAUGH				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH IANE BENNETT			
19a. INFORMANT'S NAME (Type/Print) LARRY W. SLOAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 HEATHSIDE LANE GREENSBURG, PENNA. 17225			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) FROSTBURG CEMETERY DEC 19 1992		20c. LOCATION — City or Town, State FROSTBURG, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Cardiorespiratory Arrest							
b. Artery Sclerosis							
c. Chronic HTN and CVD							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Terry Williams M.D.				29c. LICENSE NUMBER D 16041		29d. DATE SIGNED (Month, Day, Year) 12-16-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Terry Williams M.D., Memorial Hospital Medical Building, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) DEC 17 1992				32. REGISTRAR'S SIGNATURE J. L. Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37300

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY RUTH SMITH				2. DATE OF DEATH MONTH DAY YEAR December 15, 1992		3. TIME OF DEATH 6:11 A M	
4. SOCIAL SECURITY NUMBER 212-18-1216		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT 13 1919	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 207 CENTRAL AVENUE	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) QUALITY CONTROL				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COCA COLA BOTTLING PLANT		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) WILLIAM RICKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY PORTER			
19a. INFORMANT'S NAME (Type/Print) ROBERT K. SMITH JR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 BEDFORD STREET CUMBERLAND, MARYLAND 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY DEC 17 1992		20c. LOCATION — City or Town, State CUMBERLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. DUE TO (OR AS A CONSEQUENCE OF): MI							
b. DUE TO (OR AS A CONSEQUENCE OF): CUPA							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vik Poonai</i>	
29c. LICENSE NUMBER D 36766				29d. DATE SIGNED (Month, Day, Year) DEC 15, 1992		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vik Poonai PO Box 338 Cumberland, MD 21501	
31. DATE FILED (Month, Day, Year) DEC 17 1992				32. REGISTRAR'S SIGNATURE <i>Sandra Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

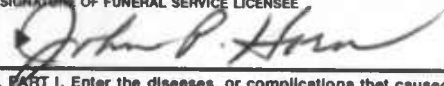
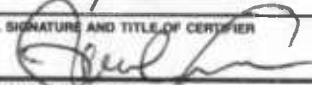

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be sent to the State as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

92 37301

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph B. Smith				2. DATE OF DEATH MONTH Dec. DAY 13 YEAR 1992				3. TIME OF DEATH 6:00 A.M.	
4. SOCIAL SECURITY NUMBER 213-12-9034		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) 9-7-1919				8. BIRTHPLACE (State or Foreign Country) Md.					
9a. FACILITY NAME (If not institution, give street and number) 43 Maple Street				9b. CITY, TOWN OR LOCATION OF DEATH Frostburg				9c. COUNTY OF DEATH Allegany	
10a. STATE Md.		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Frostburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 43 Maple Street				10f. ZIP CODE 21532				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer				16b. KIND OF BUSINESS/INDUSTRY Glass Co.	
17. FATHER'S NAME (First, Middle, Last) Charles W. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lulu Humbertson					
19a. INFORMANT'S NAME (Type/Print) Lillian Byrnes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Maple St., Frostburg, Md. 21532					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 12/16 Smithsburg, Md.				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home, Frostburg, Md.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Heart Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C.O.P.D.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER Do9157	
				29d. DATE SIGNED (Month, Day, Year) 12/13/92					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D., 124 W. 3rd St., Cumberland, Md. 21502									
31. DATE FILLED (Month, Day, Year) DEC 15 1992 32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37302

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LUCYLL STAUFFER				2. DATE OF DEATH MONTH 12 DAY 12 YEAR 1992				3. TIME OF DEATH 5:10 P M	
4. SOCIAL SECURITY NUMBER 172-05-4895		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 17, 1915	
8. BIRTHPLACE (State or Foreign Country) Louisville, Ky.				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton	
9c. COUNTY OF DEATH Talbot				10a. STATE Maryland				10b. COUNTY Caroline	
10c. CITY, TOWN OR LOCATION Federalsburg				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER Rt. 2, Box 311	
10f. ZIP CODE 21632				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Bert Embry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ray Patterson Embry					
19a. INFORMANT'S NAME (Type/Print) Earl C. Stauffer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2, Box 311, Federalsburg, Md. 21632					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cannestoga Mem. Park 12/16/92 Lancaster, Pa.				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Estow</i>				22. NAME AND ADDRESS OF FACILITY 216 N. Main Street Frampton-Hawkins-Eskow F.H. Federalsburg Md. 21632					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis a. DUE TO (OR AS A CONSEQUENCE OF): Thrombosis of aorta b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Sikes MD</i>				29c. LICENSE NUMBER D31376				29d. DATE SIGNED (Month, Day, Year) 12/14/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Sikes PO Box 496 Denton MD									
31. DATE FILED (Month, Day, Year) DEC 17 '92				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be informed at once.

92 37303

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clarence Seth				2. DATE OF DEATH MONTH DAY YEAR Dec. 18, 1992		3. TIME OF DEATH 6:30 P M	
4. SOCIAL SECURITY NUMBER 218-03-8006		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08 20 1903	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Rt.3 Box 62, Old 404		9b. CITY, TOWN OR LOCATION OF DEATH Denton	
9c. COUNTY OF DEATH Caroline				10. RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Caroline		10c. CITY, TOWN OR LOCATION Denton		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Rt.3 Box 62, Old 404				10f. ZIP CODE 21629		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 yrs.		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Food packing			
17. FATHER'S NAME (First, Middle, Last) Hayes Seth				18. MOTHER'S NAME (First, Middle, Maiden Surname) Addie Faulkner			
19a. INFORMANT'S NAME (Type/Print) Allan L. Seth, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 Jefferson Street, Wilmington, Delaware 19802			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Spring Grove Cemetery 12/22		20c. LOCATION — City or Town, State Denton, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Rudolph P. Moore</i>	
22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):				ACUTE	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):				CHRONIC	
c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. NAME AND TITLE OF CERTIFIER C. E. Jensen MD Deputy ME		29c. LICENSE NUMBER D14664		29d. DATE SIGNED (Month, Day, Year) 12/22/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. E. Jensen MD, Rt. 1, Box 118, Denton MD 21629							
31. DATE FILED (Month, Day, Year) DEC 28 '92		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injuries or other traumatic event, the medical examiner must be notified at once.

92-7371-510

blh

92 37304

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clinton F. Seeley III				2. DATE OF DEATH MONTH DAY YEAR 12 25 1992		3. TIME OF DEATH 7:42 AM	
4. SOCIAL SECURITY NUMBER 212-52-3126		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 43 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/11/49	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Shock Trauma Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2508 North Charles Street	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) one year				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Water Technician		16b. KIND OF BUSINESS/INDUSTRY Balt. City Water Dept.	
17. FATHER'S NAME (First, Middle, Last) Clinton Ford Seeley, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sara Reid			
19a. INFORMANT'S NAME (Type/Print) Clayton L. Seeley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11-D Richmar Rd., Owings Mills, MD 21117			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Unity-Washington Cem. 30		20c. LOCATION — City or Town, State Hurlock, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael F. Eskow				22. NAME AND ADDRESS OF FACILITY Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 12 25 1992		28b. TIME OF INJURY 6:48 AM	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED Operator in motorcycle acc			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) on street				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Druid Park Dr. & Eutaw St			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 12 26 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) DEC 30 '92				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 and 7 should be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37305

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JACK W. STREETON						2. DATE OF DEATH MONTH 12 DAY 19 YEAR 1992		3. TIME OF DEATH 10:15 AM	
4. SOCIAL SECURITY NUMBER 571-18-2992		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-1-1917		8. BIRTHPLACE (State or Foreign Country) California	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Oxford				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4501 World Farm Road				10f. ZIP CODE 21654		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1939-1968		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military Officer		16b. KIND OF BUSINESS/INDUSTRY U.S.A.F.			
17. FATHER'S NAME (First, Middle, Last) Perceival Hall Streeton						18. MOTHER'S NAME (First, Middle, Maiden Surname) Neva E. Smith			
19a. INFORMANT'S NAME (Type/Print) Katharine S. Issa				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1598 Parkview Drive, Vista, CA 92083					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oxford Cemetery		DATE 12-22		20c. LOCATION — City or Town, State Oxford, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M-K Newnam C.F.S.P.				22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Exuberant Arteriovenous Thromboses DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 3 mos	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. probable sarcomatosis DUE TO (OR AS A CONSEQUENCE OF):						2 mos.	
		c. ASHD & CHF DUE TO (OR AS A CONSEQUENCE OF):						2 wks	
		d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER E. H. Wilson				29c. LICENSE NUMBER D12480		29d. DATE SIGNED (Month, Day, Year) 12-19-92			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E.H. Wilson									
31. DATE FILED (Month, Day, Year) DEC 24 1992		32. REGISTRAR'S SIGNATURE John A. Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37306

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHRYN Marguerite STULTZ				2. DATE OF DEATH MONTH 12 DAY 24 YEAR 92		3. TIME OF DEATH 11:00 A M	
4. SOCIAL SECURITY NUMBER 220-28-8087		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/5/14	
9a. FACILITY NAME (If not institution, give street and number) 2061 N. FEESER ROAD				9b. CITY, TOWN OR LOCATION OF DEATH TANEYTOWN		9c. COUNTY OF DEATH CARROLL	
10a. STATE Maryland				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Taneytown	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2061 N. Feeser Road				10f. ZIP CODE 21787		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Sewing Factory			
17. FATHER'S NAME (First, Middle, Last) James W. Hahn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Hilbert			
19a. INFORMANT'S NAME (Type/Print) Patricia Porter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2061 N. Feeser Road, Taneytown, MD 21787			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. LOCATION — City or Town, State Eldersburg, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sue Ann Elaherty Dyer</i>				22. NAME AND ADDRESS OF FACILITY Myers Funeral Home 91 Willis St. Westminster, MD 21157			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE FAILURE (HEART) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 7 yrs > 10 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wm. R. Linticum, M.D.</i>				29c. LICENSE NUMBER D14317		29d. DATE SIGNED (Month, Day, Year) 12/24/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wm. R. LINTICUM, M.D., ONE KINGS DRIVE, TANEYTOWN, MD 21787							
31. DATE FILED (Month, Day, Year) DEC 28 '92		32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodale</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be completed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 is marked, or other traumatic event, the medical examiner must be notified at once.

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92 37307

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard Lewis Stroh, Sr.				2. DATE OF DEATH MONTH DAY YEAR Dec. 23, 1992		3. TIME OF DEATH 1:30 pm	
4. SOCIAL SECURITY NUMBER 219-42-5392		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 4, 1943	
8. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center				9. CITY, TOWN OR LOCATION OF DEATH Towson		10. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4117 Littlestown Pike				10f. ZIP CODE 21158		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Line Machanic		16b. KIND OF BUSINESS/INDUSTRY Plastic Containers	
17. FATHER'S NAME (First, Middle, Last) Charles Eugene Stroh				18. MOTHER'S NAME (First, Middle, Maiden Surname) E. Naomi Lampe			
19a. INFORMANT'S NAME (Type/Print) Linda Stroh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4117 Littlestown Pike, Westminster, Md. 21158			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Mem. Gardens 12/28/92 Finksburg, Md.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. Schmitt</i>				22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Cell Carcinoma							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute renal failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Huslig MD</i>				29c. LICENSE NUMBER D36814		29d. DATE SIGNED (Month, Day, Year) 12-24-92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard L. Huslig, 7505 Osler Dr., #504 Towson, MD 21204							
31. DATE FILED (Month, Day, Year) 12-24-92		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the cause of death has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

92 37308

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Joseph Frances Taylor | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Dec. 20, 1992 | | 3. TIME OF DEATH
6:58 P. M | |
| 4. SOCIAL SECURITY NUMBER
220-16-7302 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
65 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JUNE 23, 1927 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number)
Physicians Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LaPlata | | | 9c. COUNTY OF DEATH
Charles | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
CHARLES | | 10c. CITY, TOWN OR LOCATION
MARBURY | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
P.O. BOX #428 | | | | 10f. ZIP CODE
20658 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE YEAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (8-12) 11TH GRADE
College (1-4 or 5+) NONE | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
EXPLOSIVE WORKER | | | 16b. KIND OF BUSINESS/INDUSTRY
GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES TAYLOR | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MASCIEL SMALLWOOD TAYLOR | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
SARAH TAYLOR | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX #428 MARBURY, MARYLAND 20658 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
MARYLAND VETERANS CEMETERY | | | 20c. LOCATION — City or Town, State
CHELTENHAM, MARYLAND | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Lydia C. Thornton Johnson</i>
LYDIA C. THORNTON JOHNSON | | | | 22. NAME AND ADDRESS OF FACILITY
THORNTON'S FUNERAL HOME, POMONKEY, MARYLAND | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
<u>years</u>
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Charles Co Deputy MF</i>
Charles Co Deputy MF | | | | | | 29c. LICENSE NUMBER
D-27348 | | 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Howard M. Haft, M.D., 4F Industrial Park Drive, Waldorf, Maryland 20604 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | 32. REGISTRAR'S SIGNATURE
<i>Lidia Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any trauma, or other traumatic event, the medical examiner must be notified at once.

92 37309

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)
Bedford Hackett Turner Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 17 1992 | | 3. TIME OF DEATH
11:35AM M | |
| 4. SOCIAL SECURITY NUMBER
215-38-1811 | | 5. SEX
XX M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11-19-1908 | |
| 8a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital at Easton | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Talbot | | 10c. CITY, TOWN OR LOCATION
Oxford | | 10d. INSIDE CITY LIMITS?
XX YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
211 S. Morris St. | | | | 10f. ZIP CODE
21654 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
W.W.II- | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (8-12)
11 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Lawyer | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Bedford Hackett Turner, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alice Bertha Whiteley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dorothy Y. Turner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 292, Oxford, MD 21654 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Salisbury Crematory 12-18 | | 20c. LOCATION — City or Town, State
Salisbury, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
M. E. Newnam | | | | 22. NAME AND ADDRESS OF FACILITY
Newnam Funeral Home, P.A.
200 S. Harrison St., Easton, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Acute Renal Failure</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. <u>Obstructive Uropathy</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. <u>Metastatic Carcinoma of Prostate</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Intestinal Obstruction 2nd La Prostate</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Wm H Wood MD | | | | 29c. LICENSE NUMBER
D08715 | | 29d. DATE SIGNED (Month, Day, Year)
12/18/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William H Wood Jr EASTON, MD 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | 32. REGISTRAR'S SIGNATURE
L. R. Anderson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37310

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ida ELIZABETH Turner | | | | 2. DATE OF DEATH
MONTH 12 DAY 7 YEAR 92 | | 3. TIME OF DEATH
6:10 P M | |
| 4. SOCIAL SECURITY NUMBER
217-30-8710 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4-8-10 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| 10a. STATE
MD | | | | 10b. COUNTY
TALBOT | | 10c. CITY, TOWN OR LOCATION
EASTON | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
6091 LANDING KNECK RD | | | | 10f. ZIP CODE
21601 | | 10g. CITIZEN OF WHAT COUNTRY?
U S A | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
UNKNOWN | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
CLEANING | | 16b. KIND OF BUSINESS/INDUSTRY
DOMESTIC ENGINEER | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES WELLS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ELIZABETH TILGHMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
WALTER BLAKE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6117 landing kneck rd EASTON MD 21601 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
richardson cemetery 12/12 EASTON MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
315-Deane St Easton md
SERVICES | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Unknown | | | | | |
| | | b. malnutrition | | | | | |
| | | c. Hypertension | | | | | |
| | | d. Diabetes | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
042815 | | 29d. DATE SIGNED (Month, Day, Year)
12/8/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
B. Baroque mo 607 Dutchmans Ln Easton mo 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 18 1992 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37311

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Marguerite B. Tubman | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 15, 1992 | | 3. TIME OF DEATH
7:30 PM | |
| 4. SOCIAL SECURITY NUMBER
215-54-5426 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 23, 1903 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | 10b. COUNTY
Charles | | 10c. CITY, TOWN OR LOCATION
Indian Head | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
12 Greenwood Place | | | | 10f. ZIP CODE
20640 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thaddeus Clifford Berry | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anne Gilmore Montgomery | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marilyn C. Tubman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4857 Battery Lane, #505, Bethesda, MD 20814 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 12/19/92 | | 20c. LOCATION — City or Town, State
Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Nichelle P. Kutta</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, MD 20814-3501 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Intracerebral Hemorrhage</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D37891 | | 29d. DATE SIGNED (Month, Day, Year)
12/16/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
AMIT DATTA 541 MD 10313 Georgia Ave #302 Silver Spring MD 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 18 '92 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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92 37312

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ARTHUR ALEXIS VARELA | | | | 2. DATE OF DEATH
MONTH 12 DAY 14 YEAR 1992 | | 3. TIME OF DEATH
1:37 A | |
| 4. SOCIAL SECURITY NUMBER
577-50-8716 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4-14-1908 | |
| 9a. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
BALTIMORE CITY | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Talbot | | 10c. CITY, TOWN OR LOCATION
Easton | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
6648 Peachblossom Pt. Road | | | |
| 10f. ZIP CODE
21601 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Electronic Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
Research | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Edmund Albert Varela | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret Birney | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Anna D. Varela | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6648 Peachblossom Pt. Rd., Easton, MD 21601 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Salisbury Crematory 12-16 Salisbury, MD | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
JOHN R. MERCERON CESP | | | | 22. NAME AND ADDRESS OF FACILITY
Newnam Funeral Home, P.A.
200 S. Harrison St., Easton, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary embolism
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
12 hr |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Wendy Johnson MD | | | | 29c. LICENSE NUMBER
P04749 | | 29d. DATE SIGNED (Month, Day, Year)
12/14/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Wendy Johnson 600 N. Wolfe St. Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 16 1992 | | 32. REGISTRAR'S SIGNATURE
John R. Mercer | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Registrar certifies that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEM: 1 PER F.H. G-695 1/14/93 reb

92 37314

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME
AGNES
EARNESTINE CLAYTON WRIGHT | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-01-92 | | 3. TIME OF DEATH
M | | | | | |
| 4. SOCIAL SECURITY NUMBER
214-28-3418 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
04-05-03 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
CORSICA HILLS NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CENTREVILLE | | | | 9c. COUNTY OF DEATH
QUEEN ANNES | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
KENT | | 10c. CITY, TOWN OR LOCATION
WORTON | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
ROUTE 1 BOX 145 | | | | 10f. ZIP CODE
21678 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 3rd
College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
DOMESTIC | | | | 16b. KIND OF BUSINESS/INDUSTRY
DOMESTIC | | | |
| 17. FATHER'S NAME (First, Middle, Last)
PHILLIP WRIGHT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ELIZABETH HENDERSON | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MARY EMILY CLAYTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
305 HAMILTON ST. N. W. APT. 10, WASHINGTON, D.C. | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
UNION U. M. CHURCH CEM. 12-05-92 COLEMAN, MD. | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
BENNIE SMITH FUNERAL SERV.
P.O. BOX 691, DOVER, DE. 19903 | | | | | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebral Vascular Accident</u>
DUE TO (OR AS A CONSEQUENCE OF):
Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Arteriosclerosis</u>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>① Old CVA involving Bilateral Cerebral Hemisphere ② DM. ③ ASHD</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL:
1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 28. PLACE OF DEATH (Check only one)
OTHER:
4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>K. K. WUN, M.D.</u> | | | | 29c. LICENSE NUMBER
<u>021313</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>12/31/92</u> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>KIN K. WUN 216 High St, Chestertown, Md 21620</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>DEC 31 '92</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>J. Davidson</u> | | | | | | | |

05 0014

92 37315

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Bessie Elizabeth Wright | | | | 2. DATE OF DEATH
MONTH 12 DAY 19 YEAR 92 | | 3. TIME OF DEATH
2:37 p.m. | |
| 4. SOCIAL SECURITY NUMBER
220-03-4528 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
84 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
08-10-08 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
CAROLINE | | 10c. CITY, TOWN OR LOCATION
DENTON | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
ROUTE 3 BOX 116 | | | | 10f. ZIP CODE
21629 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
10th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
LABORER | | 16b. KIND OF BUSINESS/INDUSTRY
POULTRY PLANT | | | |
| 17. FATHER'S NAME (First, Middle, Last)
DANIEL LAKE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
DAISY WRIGHT | | | |
| 19a. INFORMANT'S NAME (Type/Print)
TERENDA THOMAS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROUTE 3, BOX 117, DENTON, MD. 21629 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SPRING GROVE CEMETERY 12-23-92 | | 20c. LOCATION — City or Town, State
DENTON, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John H. Grice</i> | | | | 22. NAME AND ADDRESS OF FACILITY
BENNIE SMITH FUNERAL SERV.
426 DOVER ROAD, EASTON, MD. 21601 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <i>Renal Failure</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>End-stage Renal Disease</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>Nephrosclerosis</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| <i>Organic Mental Syndrome</i> | | | | | | | |
| <i>Recent onset Atrial Fibrillation</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Wm H Wood MD</i> | | | | 29c. LICENSE NUMBER
<i>D08715</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12/20/92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>W M H Wood MD EASTON, MD 21601</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 23 1992</i> | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37316

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|---|--|----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LEE BERNARD WHITE | | | | 2. DATE OF DEATH
MONTH 12 DAY 16 YEAR 1992 | | 3. TIME OF DEATH
10:25 AM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
213-05-5102 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-11-1906 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | | 9c. COUNTY OF DEATH
Talbot | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Talbot | | 10c. CITY, TOWN OR LOCATION
Easton | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER
7078 Dogwood Terrace | | | | 10f. ZIP CODE
21601 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
10 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Electrician | | 16b. KIND OF BUSINESS/INDUSTRY
self-employed | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Lee A. White | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sallie E. Phillips | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Clara J. White | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7078 Dogwood Terrace, Easton, MD 21601 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Oxford Cemetery 12-19 | | 20c. LOCATION — City or Town, State
Oxford, MD 21654 | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
JOHN R. MERCERON CFS | | | | 22. NAME AND ADDRESS OF FACILITY
Newnam Funeral Home, P.A.
200 S. Harrison St., Easton, MD 21601 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
metastatic
DUE TO (OR AS A CONSEQUENCE OF):
carcinoma of pancreas
DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death
2 months | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Albert T. Dawkins, Jr., M.D. | | 29c. LICENSE NUMBER
802824 | | 29d. DATE SIGNED (Month, Day, Year)
12/16/92 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Albert T. Dawkins, Jr., M.D., 508 Idlewild Avenue, Easton, MD | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 18 1992 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,


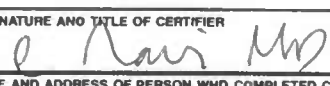

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

92 37317

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LADYS Burt WELCH | | | | 2. DATE OF DEATH
MONTH 12 DAY 24 YEAR 92 | | 3. TIME OF DEATH
0905A | |
| 4. SOCIAL SECURITY NUMBER
241-12-8786 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
72 YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | 7. DATE OF BIRTH (Month, Day, Year)
Dec. 26, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country)
North Carolina | | | | 9. FACILITY NAME (If not institution, give street and number)
Baltimore County Gen. Hospital | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH
Randallstown | | | | 11. COUNTY OF DEATH
U.S.A. Baltimore | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Reisterstown | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
10 Sunnysdale Way | | | | 10f. ZIP CODE
21136 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (14 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
X-Ray Technician | | 16b. KIND OF BUSINESS/INDUSTRY
Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last)
J. Vernon Welch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mamie D. ? | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Stephanie Karpin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14 Sunny King Drive., Reisterstown, Md. 21136 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Evergreen Mem. Gardens 12/29/92 | | 20c. LOCATION — City or Town, State
Finksburg, Md. | | 20d. DATE
12/29/92 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Eckhardt Funeral Chapel 21117
11605 Reisterstown Rd., Owings Mills, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. METASTATIC BREAST CANCER | | | | | |
| | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
AODM. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. DATE OF INJURY (Month, Day, Year) | | | |
| 29. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
037333 | | 29d. DATE SIGNED (Month, Day, Year)
12.24.92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
C. RAVI, BCGH, RANDALLSTOWN, MD 21133 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 28 '92 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37318

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HAZEL W. WERNZ | | | | 2. DATE OF DEATH
MONTH 12 DAY 23 YEAR 92 | | 3. TIME OF DEATH
10:50 A M | |
| 4. SOCIAL SECURITY NUMBER
214-01-3897 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
1-22-07 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
ST. JOSEPH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
TOWSON, MD | |
| 9c. COUNTY OF DEATH
BALTO. | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Baltimore | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1802 Yakona Rd. | | | |
| 10f. ZIP CODE
21234 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9
College (1-4 or 5+) 9 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Telephone Operator | | 16b. KIND OF BUSINESS/INDUSTRY
C&P Telephone Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Elias F. Taylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bertha Ward | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joan T. Bond | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1802 Yakona Rd. Baltimore, Md. 21234 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Carrollton Ch. of God | | 20c. DATE
12/28 | | 20d. LOCATION — City or Town, State
Finksburg, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Nancy L. Fletcher</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Thomas D. Fletcher & Son F.H.
254 E. Main St. Westminster, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute myocardial Infarction | | | | Approximate Interval Between Onset and Death
4 hours | |
| | | b. Probable Septic shock | | | | 4 hours | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. _____ | | | | | |
| | | d. _____ | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
osteoporosis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John Doyle MD</i> (DOYLE) | | | | 29c. LICENSE NUMBER
D 30749 | | 29d. DATE SIGNED (Month, Day, Year)
12/23/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JAMES DOYLE MD 7620 YORK RD TOWSON, MD. 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 28 92 | | 32. REGISTRAR'S SIGNATURE
<i>John Bond</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

GMN

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37319

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|--|--|--|--|
| Delante | | | | Alexander | | | | 12 31 1992 11:36 P.M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| | | | | YRS. | | 3 3 | | | | 9-8-92 | | Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| Sinai Hospital | | | | | | | | Baltimore City | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| Md. | | | | Baltimore City | | | | | | | | | | | |
| 10e. STREET AND NUMBER | | | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| 2019 Madison Ave. | | | | | | 21217 | | | | USA | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | Child | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | |
| Stewart McQueen | | | | | | Jacqueline Alexander | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | |
| Jacqueline Alexander | | | | | | 2019 Madison Ave. Balt. Md. 21217 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| | | | | Mt Zion | | | | 11/8/93 | | Baltimore, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| [Signature] | | | | | | William C. Brown Community Pk
1206 W. North Ave. | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | | | | | |
| a. SUFFOCATION | | | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | | | | | |
| | | | | HOSPITAL:
1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | | | OTHER:
4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | FUND: 12/31/92 | | 11:00 P | | | | SUFFOCATED BY OVERLYING | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | | | | HOME | | | | | | 1937 W. NORTH AVE.
BALTIMORE, MD. | | | | | |
| 29a. CERTIFIER
(Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| [Signature] | | | | | | | | O.C.M.E. | | | | 1/01/1993 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | | | |
| 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| JAN 6 1993 | | | | [Signature] | | | | | | | | | | | |

DMMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

ION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL AND/OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

92 37320

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Carrie L Allen | | | | 2. DATE OF DEATH
MONTH 12 DAY 27 YEAR 92 | | 3. TIME OF DEATH
10:00 p. m. | |
| 4. SOCIAL SECURITY NUMBER
579-30-5609 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4/13/02 | |
| 8. BIRTHPLACE (State or Foreign Country)
Saluda, SC | | | | 9a. FACILITY NAME (If not institution, give street and number)
13305 Bea Kay Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Md | | 10b. COUNTY
Mont | |
| 10c. CITY, TOWN OR LOCATION
Silver Spring | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
13305 Bea Kay Drive | |
| 10f. ZIP CODE
20904 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Yrs
College (1-4 or 5+) None | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
File Clerk | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank Washington | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Fannie Springs | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Fannie Stinson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10a,b,c,d,e,&f | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Md National Memorial Park 12/31/92 | | 20c. LOCATION — City or Town, State
Laurel, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Juan Smith</i> | | | | 22. NAME AND ADDRESS OF FACILITY
John T Rhines Co., Inc.
3030 12th St NE, DC 20017 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i>
DUE TO (OR AS A CONSEQUENCE OF):
CVA
DUE TO (OR AS A CONSEQUENCE OF):
<i>Hypertension</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Hypertension</i>
<i>Atherosclerotic vascular disease</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Charles L. Franklin, Jr.</i> | | | | 29c. LICENSE NUMBER
D14404 | | 29d. DATE SIGNED (Month, Day, Year)
12/28/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles L. Franklin, Jr., M.D. 11120 New Hampshire Avenue, Silver Spring, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Benjamin-Russell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CYNTHIA CELESTINE BODDIE | | | | | | 2. DATE OF DEATH
MONTH 12 DAY 28 YEAR 92 | | 3. TIME OF DEATH
1:45 PM | | | |
| 4. SOCIAL SECURITY NUMBER
578-74-9309 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
7/26/54 | | 8. BIRTHPLACE (State or Foreign Country)
DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
415 SILVER SPRING AVENUE | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRING | | 9c. COUNTY OF DEATH
MONTGOMERY | | | |
| 10a. STATE
Md | | | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Silver Spring | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 10e. ZIP CODE
20910 | | 10f. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Yrs
College (1-4 or 5+) 8 Yrs | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Medical Assistant | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John C Boddie | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Waller | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Thompkins | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4317 8th St NW, DC 20011 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park 1/2/93 | | DATE
Landover, Md. | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert L. Plummer | | | | | | 22. NAME AND ADDRESS OF FACILITY
John T Rhines Co., Inc.
3030 12th St NE, DC 20017 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC INTOXICATION
DUE TO (OR AS A CONSEQUENCE OF):

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | | Approximate Interval Between Onset and Death | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John T. Rhines | | | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/29/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GONZ JR. MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | 32. REGISTRAR'S SIGNATURE
John T. Rhines | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH


REG. NO.

92 37322

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Osie B. Collins | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 31, 1992 | | 3. TIME OF DEATH
M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
225 16 4649 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 15, 1920 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
407 Souse Dr. House B | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Severna Park | | | 9c. COUNTY OF DEATH
Anne Arundel | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Annapolis | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER
959 Aqua Ct. | | | | 10f. ZIP CODE
21401 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 3
College (1-4 or 5+) Sales Clerk | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Sales Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Retail | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
A. P. Burnette | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alice E. Taylor | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mike Leverington | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
959 Aqua Ct., Annapolis, MD 21401 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 1/4/93 | | OATE | | 20c. LOCATION — City or Town, State
Crownsville, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
McCully Funeral Home of Pasadena
3204 Mountain Rd., Pasadena, MD 21122 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____ | | | | | | Approximate Interval Between Onset and Death
16 mos. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_____ | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER
(Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert Dert Jr MD | | 29c. LICENSE NUMBER
D39660 | | 29d. DATE SIGNED (Month, Day, Year)
1/2/93 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert Dert 707 E. Fort Ave Baltimore 21230 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR SIGNATURE
 | | | | | | | | | |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate and page 6 should be retained by the funeral director. TO THE HEALTH DEPARTMENT: This certificate should be detached from page 5 and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



THE END

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

92 37324

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY LEE DIXON | | | | 2. DATE OF DEATH
MONTH December DAY 26 YEAR 1992 | | 3. TIME OF DEATH
1245 M | |
| 4. SOCIAL SECURITY NUMBER
217-22-4472 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
78 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
8-24-1914 | 8. BIRTHPLACE (State or Foreign Country)
Virginia | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SALISBURY | | 9c. COUNTY OF DEATH
WICOMICO | |
| 10a. STATE
Delaware | | | | 10b. COUNTY
Frankford | | 10c. CITY, TOWN OR LOCATION
Frankford | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
Rt. 26 RD 3 242K | | 10f. ZIP CODE
19945 | |
| 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES <input checked="" type="checkbox"/> | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
10 years | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Assembler | | | | 16b. KIND OF BUSINESS/INDUSTRY
Bendix Radio | | 17. FATHER'S NAME (First, Middle, Last)
Robert Hartsock | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Victoria Minton | | | | 19a. INFORMANT'S NAME (Type/Print)
Harold F. Dixon | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2010 Poplar Ridge Rd. Pasadena Md. 21122 | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Gardens of Faith Cemetery 12/30/92 Balto., Md. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Lassahn Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lassahn Funeral Home
7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
b. Hypertensive vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
d. Arteriosclerotic Cardiovascular Disease to Myocardial Infarction, Pulmonary Disease, Vascular Thrombosis | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Cardiovascular Disease to Myocardial Infarction, Pulmonary Disease, Vascular Thrombosis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFY (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Helen M. Baldado M.D.</i> |
| 29c. LICENSE NUMBER
D16840 | | | | | | | 29d. DATE SIGNED (Month, Day, Year)
12/29/92 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Helen Baldado 547 F Riverside Dr. Salisbury, Md. 21801 | | | | | | | |
| 31. DATE FILLED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37325

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GRACE L DAVIS | | | | 2. DATE OF DEATH
MONTH 12 DAY 31 YEAR 92 | | 3. TIME OF DEATH
3:44A (M) | |
| 4. SOCIAL SECURITY NUMBER
213301906 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1/22/34 | |
| 8. BIRTHPLACE (State or Foreign Country)
S.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
BON SECOURS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTO, MD | |
| 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Balto. | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1701 Eutaw Pl #313 | | | | 10f. ZIP CODE
21217 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
Walter Nelson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Annie Oliver | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Arthur W. Davis, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City, or Town, State, Zip Code)
1572 Carswell St. Baltimore, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Garrison Forest VA. Cem. | | 20c. LOCATION — City or Town, State
Owings Mills, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Suzette K. Jones | | | | 22. NAME AND ADDRESS OF FACILITY
Wm. C. March F.H. 1101 E. North Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Adenocarcinoma of the Lung | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| | | | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Christie G. Lamping | | | | 29c. LICENSE NUMBER
D32263 | | 29d. DATE SIGNED (Month, Day, Year)
12/31/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHRISTIE LAMPING 5000 W Baltimore 21223 | | | | | | | |
| 31. DATE SIGNED (Month, Day, Year)
JAN 6 1993 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

—

92 37326

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOHN BEVAN FOARD, JR | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-23-92 | | 3. TIME OF DEATH
9A M | |
| 4. SOCIAL SECURITY NUMBER
215 34 7572A | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
5/2/1913 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
5836 Williams Road | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hydes/Glen Arm | |
| 9c. COUNTY OF DEATH
BALTIMORE COUNTY | | | | 10a. STATE
Maryland | | 10b. COUNTY
Baltimore County | |
| 10c. CITY, TOWN OR LOCATION
Hydes/Glen Arm | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
5836 Williams Road | |
| 10f. ZIP CODE
21082 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY
Farmer | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John B. Foard | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mina R. Bevan | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs Ruth Foard | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5836 Williams Road, Hydes, MD 21082 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ronald Wade, Dir
1/5/93 | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board
655W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Dementia</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Decubitus Ulcers Multiple</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Alan Baldanca</u> | | | | 29c. LICENSE NUMBER
X | | 29d. DATE SIGNED (Month, Day, Year)
12/29/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR ALAN BALDANCA
10629 York Rd, Cockeysville, MD 21030 | | | | 31. DATE FILED (Month, Day, Year)
JAN 06 1993 | | | |
| 32. REGISTRAR'S SIGNATURE
<u>John B. Foard</u> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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REG. NO.

DHMH-16 Rev 1/89



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BENJAMIN H GIBSON | | | | 2. DATE OF DEATH
MONTH 12 DAY 25 YEAR 1992 | | 3. TIME OF DEATH
6:50 PM | |
| 4. SOCIAL SECURITY NUMBER
218 36 9395 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-9-1942 | |
| 9a. FACILITY NAME (If not institution, give street and number)
501 WEST FRANKLIN STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 9c. COUNTY OF DEATH
na | |
| 10a. STATE
Maryland | | 10b. COUNTY
na | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Seton Hill Manor Franklin Street | | | | 10f. ZIP CODE
21201 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) na | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY
na | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Benjamin Harrison Gibson Sr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lorraine Grant | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LARRY GIBSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
237 LAMBETH RD BALTIMORE, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT AUBURN CEMETERY | | DATE
1-4-93 | | 20c. LOCATION — City or Town, State
BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
MUTTER FUNERAL HOMES INC
2501 GWYNNS FALLS PKWY BALTO, MD 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Schizophrenia | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Donald G Wright MD | | | | | |
| 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/26/1992 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE
JAN 6 1993 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
VIRGINIA JOHNSON HAYS | | | | 2. DATE OF DEATH
MONTH 12 DAY 26 YEAR 92 | | 3. TIME OF DEATH
3:40 P M | |
| 4. SOCIAL SECURITY NUMBER
577-42-3159 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
03/31/1931 | |
| 9a. FACILITY NAME (If not institution, give street and number)
3700 W. Forest Park Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City, Md. | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore City, Maryland | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3700 W. Forest Park Avenue | | | | 10f. ZIP CODE
21216 | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH Grade
College (1-4 or 5+) College Grad. | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Public Sch. Teacher-Balto. City | | 16b. KIND OF BUSINESS/INDUSTRY
Dept. Of Education | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Herbert Lincoln Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ruth Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Daniel Henry Hays | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3700 W. Forest Park Avenue Balto. Md. 21216 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Druid Ridge Cem. 12/30/92 | | 20c. LOCATION — City or Town, State
Balto. city. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Herbert E. Muttter | | | | 22. NAME AND ADDRESS OF FACILITY
Mutter Funeral Homes, Inc 21216
2501 Gwynn Falls PKwy. Balto., Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Metastatic Esophageal Carcinoma</u> | | | | | Approximate Interval Between Onset and Death
<u>one year</u> |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Diabetes Mellitus</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Dr. H. H. Hays</u> | | | | 29c. LICENSE NUMBER
<u>D36814</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>12/29/92</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
<u>1505 Oak Drive, Towson, MD 21204 suite 504</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37330

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LEON HARRY HATMAKER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-22-92 | | 3. TIME OF DEATH
10P | |
| 4. SOCIAL SECURITY NUMBER
409 10 8143 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10-10-14 | |
| 8. BIRTHPLACE (State or Foreign Country)
Tenn | | | | 9a. FACILITY NAME (If not institution, give street and number)
508 Sylvan Way | | 9b. CITY, TOWN OR LOCATION OF DEATH
Pasadena | |
| 9c. COUNTY OF DEATH
Anne Arundel Co | | | | 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel County | |
| 10c. CITY, TOWN OR LOCATION
Pasadena | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
995 9th Street | |
| 10f. ZIP CODE
21122 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY
Crane Operator | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Wiley Henry Hatmaker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lizzie Ragle | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs Frankie Hatmaker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
995 9th Street, Pasadena, MD 21122 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | |
| 20c. LOCATION — City or Town, State | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | |
| 22. NAME AND ADDRESS OF FACILITY State Anatomy Board
655 W. Baltimore St, Balto, MD 21201 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sporadic Cell Cancer of the lung
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| 24. Approximate Interval Between Onset and Death | | | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease
Emphysema
Black lung | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | |
| 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Michael G. Sylva MD | | | | 29c. LICENSE NUMBER
034109 | | | |
| 29d. DATE SIGNED (Month, Day, Year)
12/29/92 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR SYLVA 1600 Crain Highway, 1600 Crain Highway #302, Glen Burnie, MD 21061 | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 06 1993 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be retained by the funeral director, page 4 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Longman & Co. 1851

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RAYMOND H. HARTMAN, SR. | | | | 2. DATE OF DEATH
MONTH 12 DAY 30 YEAR 92 | | 3. TIME OF DEATH
2:25 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER
214-50-5974 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
44 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
1/12/1948 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
S.T.U. Shock Trauma | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | | 9c. COUNTY OF DEATH
Howard Co. | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Howard Co. | | 10c. CITY, TOWN OR LOCATION
Ellicott City, | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER
8860 Town & Country Blvd, | | | | 10f. ZIP CODE
21043 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Vietnam | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12th. Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Truck Loader | | 16b. KIND OF BUSINESS/INDUSTRY
Transportation Co. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Herman Elseworth Hartman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Georgetta Frances Lang | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Angela C. Hartman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
731 Hatfield Ct. Waldorf, Md. 20602 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | DATE | | 20c. LOCATION — City or Town, State
Catonville, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Balto. Md. 21230
McCully Funeral Home, 130 E. Fort Ave. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Multiple injuries with complications</u>
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year)
12/28/92 | | 28b. TIME OF INJURY
6:47A | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
PEDESTRIAN STRUCK | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
ROADWAY | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
RTE. 104 AND RTE. 103 | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/31/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
M. Davidson D. Lawson Jr. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
IRENE L. HECK | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 30 92 | | 3. TIME OF DEATH
9:36 A.M. | |
| 4. SOCIAL SECURITY NUMBER
220 12 7324 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 4, 1916 | |
| 8. BIRTHPLACE (State or Foreign Country)
North Carolina | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
DEATON MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
Baltimore City | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Pasadena | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
716 211th St. | | | | 10f. ZIP CODE
21122 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Domestic | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Nathan R. Ingram | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillian Savage | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Norma Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7754 Outing Ave., Pasadena, MD 21122 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glen Haven Memorial Park 1/4/98 Glen Burnie, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Steph D. [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
McCully Funeral Home of Pasadena
3204 Mountain Rd., Pasadena, MD 21122 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DISEASE COMPLICATED BY DISLODGE MENT OF TRACHEOSTOMY TUBE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. TRACHEOSTOMY TUBE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
12-30-92 | | 28b. TIME OF INJURY
9:30 A.M. | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED
Accidental mal-positioning of tracheostomy tube | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
BUILDING | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Deaton Medical Center
601 S. Charles St., Balto., City, Md. | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Maya [Signature]</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12-31-1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Maya P. Wilson 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
<i>John [Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE DEATH CERTIFICATE IS A LEGAL DOCUMENT. IT MUST BE COMPLETED BY A PHYSICIAN OR A FUNERAL DIRECTOR. THE DEATH CERTIFICATE IS A LEGAL DOCUMENT. IT MUST BE COMPLETED BY A PHYSICIAN OR A FUNERAL DIRECTOR.

92 37333

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
LOUIS S. JACKSON | | | | 2. DATE OF DEATH
MONTH 12 DAY 30 YEAR 92 | | 3. TIME OF DEATH
16:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER
216-14-7187 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12-11-23 | |
| 9a. FACILITY NAME (If not institution, give street and number)
BALTIMORE COUNTY GENERAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
RANDALLSTOWN | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Randallstown | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3552 Carriage Hill Circle Apt 102 | | | | 10f. ZIP CODE
21133 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) High School
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Water Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY
Howard County Govenmet | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Stanley Jackson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Amanda Coats | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Elizabeth F. Jackson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Randallstown, MD 21133
3552 Carriage Hill Circle Apt. 102 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | 20c. LOCATION — City or Town, State
Baltimore Co., MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
H. E. Hutter | | | | 22. NAME AND ADDRESS OF FACILITY
Mutter Funeral Homes inc
2501 Gwynns Falls Parkway
Baltimore, MD 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → COMA
DUE TO (OR AS A CONSEQUENCE OF):
b. ANOXIC ENCEPHALOPATHY
DUE TO (OR AS A CONSEQUENCE OF):
c. CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA, DIABETES MELLITUS, OLD CVA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
AS Bassin
HOUSE PHYSICIAN | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
12-30-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
AVIAR...S. BASSIN
B.C.G.H. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993
J. H. Jackson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

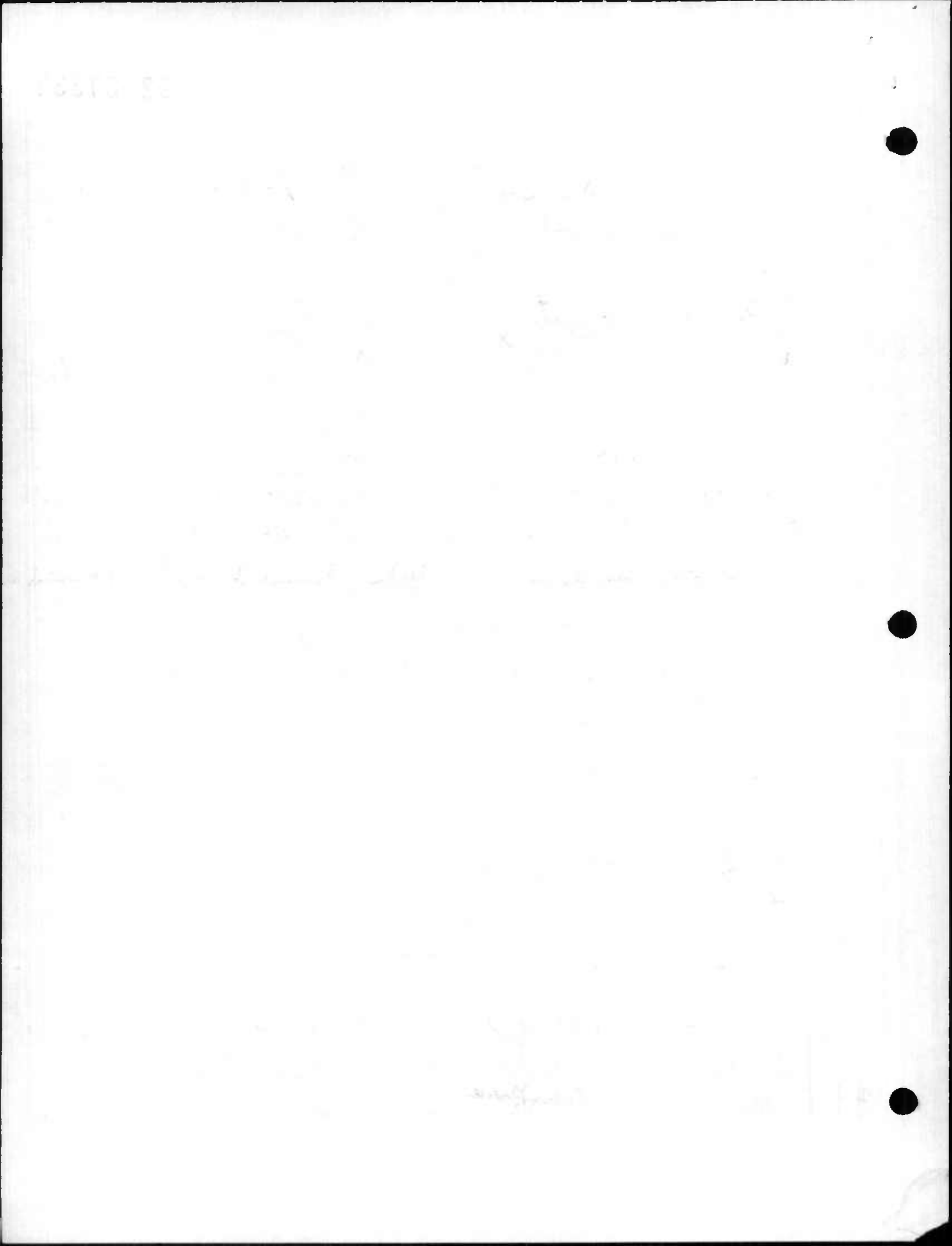
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37334

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PEARL JOHNSON | | | 2. DATE OF DEATH
MONTH 12 DAY 31 YEAR 92 | | 3. TIME OF DEATH
M |
| 4. SOCIAL SECURITY NUMBER
219-20-5481 | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
82 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year)
1-29-10 |
| 8. BIRTHPLACE (State or Foreign Country)
MD | | | 9. COUNTY OF DEATH
MD | | |
| 9a. FACILITY NAME (If not institution, give street and number)
2228 Orleans ST | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Balto. md | | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
MD | 10b. COUNTY
MD | 10c. CITY, TOWN OR LOCATION
Balto. | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2228 Orleans ST | | 10f. ZIP CODE
21205 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) ? College (1-4 or 5+) ? | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Rudder | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lena Hickman | | |
| 19a. INFORMANT'S NAME (Type/Print)
BARBARA Thomas | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5916 The Alameda BALTO. MD 21239 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
MT. CATHARY CEMETERY 1/6 | | 20c. LOCATION — City or Town, State
A.A. County MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Timothy Randon | | 22. NAME AND ADDRESS OF FACILITY
Locke Funeral Home / 1304 N Central | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → DILATED CARDIOMYOPATHY
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {
a. DUE TO (OR AS A CONSEQUENCE OF):
VENTRICULAR ARRHYTHMIAS
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
William F. Davis, MD | | 29c. LICENSE NUMBER
D3803 | | 29d. DATE SIGNED (Month, Day, Year)
1/4/93 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
IRENE F. IBARRA 100 N. BROADWAY ST. | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | 32. REGISTRAR'S SIGNATURE
John Davidson Randall | | | |

6310 50



92 37335

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Edith T. Landon | | | | 2. DATE OF DEATH
MONTH 13 DAY 26 YEAR 92 | | 3. TIME OF DEATH
3:50 P M | |
| 4. SOCIAL SECURITY NUMBER
217-24-1057 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12/08/19 | |
| 8. BIRTHPLACE (State or Foreign Country)
Baltimore | | | | 9a. FACILITY NAME (If not institution, give street and number)
Bon Secor Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City, Md. | |
| 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
124 W. FRANKLIN STREET | | | | 10f. ZIP CODE
21201 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
Secondary Sch. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
House Keeping | | 16b. KIND OF BUSINESS/INDUSTRY
Balto. City Public Sch. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Patterson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Edith Snowden | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Helen Cooper | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3810 Dolfield Avenue, Balto. Md. 21215 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | 20c. LOCATION — City or Town, State
Balto. City, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Mutter Funeral Homes Inc. 21216
2501 Gwynn Falls Pkwy. Balto. Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cardiac Arrhythmia
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Ischemic Heart Disease +
Coro.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Hypertension | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
004632 | | 29d. DATE SIGNED (Month, Day, Year)
12/26/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert R. Healey, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37336

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Frances Elizabeth Lederer | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 29, 1992 | | 3. TIME OF DEATH
9:45 P M | | |
| 4. SOCIAL SECURITY NUMBER
213-46-3744 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
4 18 11 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Maryland General Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City | | 9c. COUNTY OF DEATH | | |
| 10a. STATE
Maryland | | | | | | 10b. COUNTY
Baltimore | | 10c. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10d. STREET AND NUMBER
1524 Waverley Way | | | | | | 10e. ZIP CODE
21239 | | 10f. CITIZEN OF WHAT COUNTRY?
U. S.A. | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Samuel Irwin Austin | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lillie Lee Wilson | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Margaret L. Ferguson | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1510 Waverley Way Baltimore, Md. 21231 | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory | | DATE
12/30 | | 20c. LOCATION — City or Town, State
Baltimore, Md | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Christina S. Kopyeva</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
Johnson Funeral Home 8521 Loch Raven Blvd
Baltimore, Md. 21286 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Septic Pneumonia</i>
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Charles Kim MD</i> | | 29c. LICENSE NUMBER
N/A | | 29d. DATE SIGNED (Month, Day, Year)
12/29/92 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
C. Kim, M.D. c/o Maryland General Hospital | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | | | | | | | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37337

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BARBARA ANN MCBRIDE | | | | 2. DATE OF DEATH
MONTH 12 DAY 29 YEAR 92 | | 3. TIME OF DEATH
4:15 P M | |
| 4. SOCIAL SECURITY NUMBER
214-56-9684 | | 5. SEX
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
41 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct 6 1951 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
1251 Augusta Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore City, Md. | |
| 9c. COUNTY OF DEATH | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE
MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY, MARYLAND | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1251 AUGUST AVENUE | | | | 10f. ZIP CODE
21213 | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Social Security Adm. | | 16b. KIND OF BUSINESS/INDUSTRY
Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Alphonso L. Harris | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marjorie Hall | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marjorie Wiley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1251 Augusta Ave. Baltimore, MD 21229 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
King Memorial Park 1/2 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Mutter Funeral Home, Inc. 21216
2501 Gwynn Falls Pkwy. Balto., Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BREAST CANCER
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
035606 | | 29d. DATE SIGNED (Month, Day, Year)
12/31/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
4000 Old Court Road Suite 306 Baltimore, MD 21208 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 30 1993 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27 PER MEO G-695 1/14/93 reb

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CHARLES JEROME MARTIN, Jr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 29 92 | | 3. TIME OF DEATH
11:08 AM | |
| 4. SOCIAL SECURITY NUMBER
214-58-9477 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
39 YRS. | | 7. DATE OF BIRTH
MONTH DAY YEAR
08/07/33 | |
| 8. BIRTHPLACE (State or Foreign Country)
S.C. | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1513 Mosher St. | | | | 10f. ZIP CODE
21217 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | 16b. KIND OF BUSINESS/INDUSTRY
Industry | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles J. Martin, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mattie Oliver | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles J. Martin, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2000 Odell Ave Baltimore, MD. 21237 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
Western Star Cem | | 20c. LOCATION — City or Town, State
1/4/93 Catonsville, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Betts Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY
1129 N. CAROLINE ST. BALTO., MD. 21218 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTROPHIC CARDIOMYOPATHY
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
JASON LOCKE MD | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12-30-1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JASON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37339

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELLEN REGINA MASSEY | | | | 2. DATE OF DEATH
MONTH 12 DAY 29 YEAR 92 | | 3. TIME OF DEATH
M | |
| 4. SOCIAL SECURITY NUMBER
215-18-5696 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH
MONTH 6 DAY 23 YEAR 1922 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
123 West 29th St. (Wyman House) Apt. 5E | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE
Maryland | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
123 West 29th St. Apt. 5E | |
| 10f. ZIP CODE
21218 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
10th grade | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Waitress | | 16b. KIND OF BUSINESS/INDUSTRY
Restaurant | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Shettle, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ada Marie McGarvey | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jeannette A. Tucker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
36 Sheraton Rd. Randallstown, Md. 21131 | | | |
| 20a. METHOD OF DISPOSITION
X <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Moreland Memorial Park 1-5-1993 | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Lassahn Funeral Home</i> | |
| 22. NAME AND ADDRESS OF FACILITY
Lassahn Funeral Home
7401 Belair Rd. Balto., Md. 21236 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrhythmia (Atrial fibrillation)</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Hypertension</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Gulab M. Shah</i> | | | | 29c. LICENSE NUMBER
D26750 | | 29d. DATE SIGNED (Month, Day, Year)
12/30/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Shah 2105 N. Charles St. Baltimore, Maryland (837-1980) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100

John M. Dalry



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37340

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Rachel L. MARTIN | | 2. DATE OF DEATH
MONTH 12 DAY 30 YEAR 92 | | 3. TIME OF DEATH
1024 M | |
| 4. SOCIAL SECURITY NUMBER
218 90 6223 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
18 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
7/9/74 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | 9. CITY, TOWN OR LOCATION OF DEATH
Glen Burnie | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Pasadena | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
2210 Lake Dr. | | 10f. ZIP CODE
21122 | |
| 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
College | | 17. FATHER'S NAME (First, Middle, Last)
Richard Eugene Martin | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Carlene A. Cappelletti | | 19a. INFORMANT'S NAME (Type/Print)
Richard E. Martin | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2210 Lake Dr., Pasadena, MD 21122 | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 1/4/93 | | 20c. LOCATION — City or Town, State
Catonsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Steph D. L... | | 22. NAME AND ADDRESS OF FACILITY
McCully funeral Home of Pasadena
3204 Mountain Rd, Pasadena, MD 21122 | | 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Trauma
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
MVA | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
William P. Jones, MD Deputy | | 29c. LICENSE NUMBER
D06054 | |
| 29d. DATE SIGNED (Month, Day, Year)
12/31/92 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
William P. Jones, MD PO Box 99 20711 | | 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | |
| 32. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

01000 92

10/1/74
10/1/74

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92-7467-027

ASP

File #695, Item 1, 1/12/93, P.T.

92 37341

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | |
|--|--|--|---|---|-------------------------------------|--|--|---|---|--|---------------------------------|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM | | | | 2. DATE OF DEATH
MONTH 12 DAY 30 YEAR 1992 | | | | 3. TIME OF DEATH
3:55 A M | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
214-46-0387 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
46 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
1/3/1946 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
7070 BROOKDALE RD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Balto. (elkridge) | | | | 9c. COUNTY OF DEATH
HOWARD | | | | | | | | |
| 10a. STATE
Maryland | | | 10b. COUNTY
Anne Arundel | | | 10c. CITY, TOWN OR LOCATION
Pasadena | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
8273 Balto.-Annapolis Blvd. | | | | 10f. ZIP CODE
21122 | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
VietNam Conflict | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade
College (14 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Fork Lift Operator | | | 16b. KIND OF BUSINESS/INDUSTRY
Trucking Co. | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank P. Maydwell, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sarah V. Wehr Maydwell | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Frank P. Maydwell, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO BOX 1165 Sykesville, Md. 21784 | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 1/2/93 Balto., Md. | | | 20c. LOCATION — City or Town, State | | 20d. DATE | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Stephen Lohrmann | | | | 22. NAME AND ADDRESS OF FACILITY
McCully Funeral Home of Pasadena
3204 Mountain Rd., Pasadena, Md. 21122 | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Arteriosclerotic Cardiovascular Disease
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | | Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) JOB | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Paula Lake MD | | | 29c. LICENSE NUMBER
O.C.M.E | | | 29d. DATE SIGNED (Month, Day, Year)
12-30-1992 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
T. LARON WICKS, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and Mental Hygiene prior to burial, cremation, or removal, the medical examiner must be notified at once.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37342

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|------|--|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>George Amos Miller</u> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<u>12-30-1992</u> | | 3. TIME OF DEATH
<u>3:20 PM</u> | | | | | |
| 4. SOCIAL SECURITY NUMBER
<u>257-14-9287</u> | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>68</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>2-06-24</u> | | 8. BIRTHPLACE (State or Foreign Country)
<u>GA</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Baltimore City General</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Baltimore</u> | | | 9c. COUNTY OF DEATH | | | | |
| 10a. STATE
<u>MD</u> | | | | 10b. COUNTY | | | 10c. CITY, TOWN OR LOCATION
<u>Baltimore</u> | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
<u>2708 Ashland Ave.</u> | | | | 10f. ZIP CODE
<u>21205</u> | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>Black</u> | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>6th</u> College (1-4 or 5+) <u>Longshoreman</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>Longshoreman</u> | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Johnnie Miller</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Carrie Carter</u> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Carrie Smarts</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>311 Oklahoma Ave./Warner Robins, GA 31093</u> | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>King Memorial Park</u> | | | DATE | | 20c. LOCATION — City or Town, State
<u>Randallstown, MD</u> | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Francis J. [Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>WM C. MARCH F.H./1101 E. NORTH AVE.</u> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Acute C.I. Hemorrhage</u>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. <u>Stress ulcer</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. <u>Chemotherapy for Adenocarcinoma</u>
DUE TO (OR AS A CONSEQUENCE OF):
d. <u>Lymphoma</u> | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>A.C.D.M.</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Allen J. Chircus</u> | | | | 29c. LICENSE NUMBER
<u>029085</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>12-30-92</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Allen J. Chircus M.D. Randallstown, MD 21133</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>JAN 6 1993</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>Julia [Signature]</u> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7438-510
blh

92 37343

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|---------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James William Payne | | | | 2. DATE OF DEATH
MONTH 12 DAY 29 YEAR 1992 | | 3. TIME OF DEATH
3:56 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER
175 30 7518 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
5-16-1941 | | 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Johns Hopkins Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | | 9c. COUNTY OF DEATH
na | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
na | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
no | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 + | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
3 | | 16b. KIND OF BUSINESS/INDUSTRY
Computer Prog/Analysis | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
James Payne | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret Ann Maul | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marlene Payne | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 8, Ocean View, Delaware 19970 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation — 5 <input type="checkbox"/> Other (Specify)
in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
DATE | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Ronald Wade, Dir</i>
1/6/93 | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board
655 W. Baltimore St, Balto, MD 21201 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
a. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident
3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Mario F. Golie, Jr.</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | | | 29d. DATE SIGNED (Month, Day, Year)
12 29 1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLIE, JR., MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 06 1993 | | | | 32. REGISTRAR'S SIGNATURE
<i>Johnston</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37344

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BETTY ROTT | | | | 2. DATE OF DEATH
MONTH 12 DAY 30 YEAR 92 | | 3. TIME OF DEATH
9:29 P M | |
| 4. SOCIAL SECURITY NUMBER
218-28-1440 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10/2/33 | |
| 9a. FACILITY NAME (If not institution, give street and number)
MERCY Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baer. Md. Balt. Md | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
Md. | | | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. STREET AND NUMBER
416 E. Eager St. | | | | 10e. ZIP CODE
21218 | | 10f. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
11th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
— | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Max Papila | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Annabell Farbutton | | | |
| 19. INFORMANT'S NAME (Type/print)
Margaret Muir | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1308 Andre St. Balt. Md 21230 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Burial Home | | 20c. DATE
12/30/92 | | 20d. LOCATION — City or Town, State
Baltimore Md. 21230 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
[Signature] | | | | 22. NAME AND ADDRESS OF FACILITY
Charles E. Myers Funeral Home
1301 E. 5th Ave. Hk | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure | | | | | | | months |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Valvular Dysfunction and myocardial infarction | | | | | | | yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Coronary Artery Disease | | | | | | | yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic obstructive pulmonary disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Kathryn Calby MD House Officer | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
301 St Paul place Balto MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 92 37345 | |
|--|--|---|--|---|---|
| CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last)
CHARLES J. STEWART | | 2. DATE OF DEATH
MONTH 12 DAY 31 YEAR 1992 | | 3. TIME OF DEATH
M | |
| 4. SOCIAL SECURITY NUMBER
028-05-7228 | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
85 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
1-13-07 | | 8. BIRTHPLACE (State or Foreign Country)
NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number)
MERRIDIAN CROMWELL NUR. | | 9b. CITY, TOWN OR LOCATION OF DEATH
PARKVILLE | | 9c. COUNTY OF DEATH
BALTO. CO. | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
BALTO. CO. | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
28 DUNVALE ROAD | | 10f. ZIP CODE
21204 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
ARMY | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12): UNKNOWN
College (1-4 or 5+): | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
MANAGER-WAREHOUSE | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last)
UNKNOWN | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
UNKNOWN | | 19a. INFORMANT'S NAME (Type/Print)
FAMILY RECORDS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAME AS ABOVE | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
DUNLAP VALLEY MEM. 1-4 | | 20c. LOCATION — City or Town, State
COCKEYSVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jeffrey J. Gove LIC. # MD00677 | | 22. NAME AND ADDRESS OF FACILITY
EVANS STAFF OF CHINESE 2535 ROCK RD. TIMONIUM, MD. | | 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer LEFT PANCREAS

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. Cancer LEFT PANCREAS
DUE TO (OR AS A CONSEQUENCE OF):

b.
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF): | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MALNUTRITION | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Jim V. Sub | | 29c. LICENSE NUMBER
D 24276 | |
| 29d. DATE SIGNED (Month, Day, Year)
JAN. 4, 1993 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | |
| 32. REGISTRAR'S SIGNATURE
James H. Anderson | | | | | |

92 37346

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELBERT SLOAN | | | | 2. DATE OF DEATH
MONTH 12 DAY 23 YEAR 92 | | 3. TIME OF DEATH
6:55 P | |
| 4. SOCIAL SECURITY NUMBER
225124681 | | 6. SEX
M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
12/28/12 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | 9a. FACILITY NAME (If not institution, give street and number)
2000 W. Baltimore Street | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
U.S. | |
| 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
John Hill | | 10f. ZIP CODE
21201 | | 10g. CITIZEN OF WHAT COUNTRY?
Black | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY
County Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Gilbert Sloan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Irene Lucas | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Wilbert M. Sloan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3801 Elbert Ave., Alex, VA. 22305 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Pleasant Valley Men. Cen. Annandale, VA. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Phillip Bell | | | | 22. NAME AND ADDRESS OF FACILITY
Funeral Services Associates
2801 7th St. NE, Wash. DC | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease | | | | | | | 24b. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
NA | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
NA | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Surgeon A. J. J. J. | | 29c. LICENSE NUMBER
D 26395 | | 29d. DATE SIGNED (Month, Day, Year)
12/23/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Born Secrest Hospital Baltimore MD 21227 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report
describes the general situation
of the project. It is a very
interesting and informative
document. The second part
describes the results of the
work done during the last
year. It is a very detailed
and comprehensive report.
The third part describes the
conclusions of the work done
during the last year. It is a
very clear and concise summary
of the work done during the
last year.

4. The fourth part of the report
describes the conclusions of the
work done during the last year.
It is a very clear and concise
summary of the work done during
the last year. The fifth part
describes the conclusions of the
work done during the last year.
It is a very clear and concise
summary of the work done during
the last year.

92 37347

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mildred M. Schutz | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 28 92 | | 3. TIME OF DEATH
6:50PM M | |
| 4. SOCIAL SECURITY NUMBER
213-05-7437 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 8. AGE (In yrs. last birthday)
85 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
8/5/1907 | | 6. BIRTHPLACE (State or Foreign Country)
Baltimore | |
| 9a. FACILITY NAME (If not institution, give street and number)
Maryland Masonic Homes | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cockeysville | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Cockeysville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
300 International Circle | | | | 10f. ZIP CODE
21030-1359 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 years
College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Sales Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Hecht Company | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Richardson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Bennett | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Nancy M. Steele | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2034 Huntwood Drive Gambrills, Md. 21054 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Parkwood Cemetery | | 20c. LOCATION — City or Town, State
Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Lassahn Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lassahn Funeral Home
7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. <i>Hypoxia</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Pneumonia</i>
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dementia</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Om</i> | | | | 29c. LICENSE NUMBER
<i>D25488</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12/29/92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1952

92 37348

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LUCAS ERROL TAYLOR | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-31-92 | | 3. TIME OF DEATH
1130 P M | |
| 4. SOCIAL SECURITY NUMBER
216-16-3483 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept 24 1923 | |
| 8a. FACILITY NAME (If not institution, give street and number)
ST JOSEPH HOSPITAL TOWSON, MD | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | 8c. COUNTY OF DEATH
Maryland | |
| 10a. STATE
Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3820 Grantly Road | | | | 10f. ZIP CODE
21215 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College
College (1-4 or 5+) College | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
School Administrator | | 16b. KIND OF BUSINESS/INDUSTRY
Baltimore City | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Oliver Taylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elmira Lawrence | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mildred M. Taylor | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3820 Grantly Road Baltimore, MD 21215 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MD Veteran Cem/Crownsville | | 20c. LOCATION — City or Town, State
Crownsville, MD | | 20d. DATE
1/6 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Herbert E. Nutter | | | | 22. NAME AND ADDRESS OF FACILITY
Nutter Funeral Homes Inc
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → GASTROINTESTINAL BLEEDING

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
PEPTIC ULCER DISEASE

RENAL FAILURE
ASPIRATION PNEUMONIA
ENCEPHALOPATHY | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
ASPIRATION PNEUMONIA
ENCEPHALOPATHY | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28. DATE OF INJURY (Month, Day, Year) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Francis T. Khoo, Staff MD | | 29c. LICENSE NUMBER
D 30263 | | 29d. DATE SIGNED (Month, Day, Year)
12-31-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FRANCIS T. KHOO, MD ST. JOSEPH HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
John Pauline Rodella | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM HENRY WASHINGTON | | | | 2. DATE OF DEATH
MONTH 12 DAY 27 YEAR 92 | | 3. TIME OF DEATH
1955 M | |
| 4. SOCIAL SECURITY NUMBER
218-01-9999 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug 18 1912 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE
Maryland | | 10b. COUNTY
Baltimore | |
| 10c. CITY, TOWN OR LOCATION
Baltimore Catonsville | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1114 Arunah Avenue | |
| 10f. ZIP CODE
21228 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
World War II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) High School
College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Custodian | | | | 16b. KIND OF BUSINESS/INDUSTRY
Baltimore County Govt | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Washington | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Muir | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Shirley Diggs | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1114 Arunah Ave. Catonsville, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Baltimore Mat'l Cem 12/31 | | | |
| 20c. LOCATION — City or Town, State
Baltimore City | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Herbert E. Mitter | | | |
| 22. NAME AND ADDRESS OF FACILITY
Nutter Funeral Homes
2501 Gwynns Falls Parkway
Baltimore, MD 21216 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. END-STAGE CHRONIC OBSTRUCTIVE AIRWAY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. INTRACTABLE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL FAILURE | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
SAdeo MD | | | |
| 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year)
12-27-92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHARLACE BARKOFF-ADOO MD ST AGNES HOSP, 900 CATON AVE BALT MD 21229 | | | | 31. DATE
JAN 6 1993 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
NETTIE P. YOUNG | | | | 2. DATE OF DEATH
MONTH 12 DAY 31 YEAR 92 | | 3. TIME OF DEATH
03:31 M | |
| 4. SOCIAL SECURITY NUMBER
214-40-4771 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
09/29/15 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number)
Harbor Court Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Baltimore | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3504 White Chapel Road | | | |
| 10f. ZIP CODE
21215 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
Baltimore City | | | |
| 17. FATHER'S NAME (First, Middle, Last)
E. Warren Phillips | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth Williams | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Cartiero | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6575 Hall Ave. Glen Burnie, MD 21060 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arbutus Memorial Park 1/6 | | 20c. LOCATION — City or Town, State
Baltimore Co., MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Vernon R. Bailey | | | | 22. NAME AND ADDRESS OF FACILITY
Mutter Funeral Homes, Inc.
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CVA (HEMORRHAGIC)
HYPERTENSION | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
MD PGY1 RESIDENT | | | | 29c. LICENSE NUMBER
AS2441614-19 | | 29d. DATE SIGNED (Month, Day, Year)
12/31/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ABDUL KARIM GARUPT, MD HARBOR HOSPITAL CTR. 3001 S. HANOVER ST, BALTIMORE, MD, 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 6 1993 | | | | 32. REGISTRAR'S SIGNATURE
John Harrison-Rodriguez | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET E AMATO | | | | 2. DATE OF DEATH
MONTH 12 DAY 16 YEAR 92 | | 3. TIME OF DEATH
06:55 AM | |
| 4. SOCIAL SECURITY NUMBER
578-05-8909 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 8, 1909 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL ASSOCIATION | | 9b. CITY, TOWN OR LOCATION OF DEATH
GLEN BURNIE | |
| 9c. COUNTY OF DEATH
A.A. COUNTY | | | | 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION
Annapolis | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
107 Spring Valley Drive | |
| 10f. ZIP CODE
21403 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) Clerk | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
U.S. Government | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
Frederick M. West | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Louise Lambrecht | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marjorie A. Au | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
107 Spring Valley Dr. Annapolis, MD 21403 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATED OF DISPOSITION (Name of cemetery, crematory or other place)
Rock Creek Cemetery 12/18/92 | | 20c. LOCATION — City or Town, State
Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
4308 Suitland Rd.
Marshall's Funeral Home, Inc. Suitland, Md 20746 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Cardio myopathy | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
pneumonia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER
D23841 | | 29d. DATE SIGNED (Month, Day, Year)
12-16-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JONATHAN P FORMAN, M.D./407 S. CRAIN HIGHWAY, SUITE 105/GLEN BURNIE, MARYLAND 210 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 18 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92-7158-033
blh

92 37352

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Raymond Edwin Atkins | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 14 1992 | | 3. TIME OF DEATH
7:14 P | | | |
| 4. SOCIAL SECURITY NUMBER
218-66-5872 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
35 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 17, 1956 | | | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
9323 Alcona Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | | 9c. COUNTY OF DEATH
Prince Georges | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Lanham | | | |
| 10d. INSIDE CITY LIMITS?
1 YES 2 NO | | | | | | | | | |
| 10e. STREET AND NUMBER
9323 Alcona Street | | | | 10f. ZIP CODE
20801 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 YES 2 NO | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Meat cutter | | 16b. KIND OF BUSINESS/INDUSTRY
Retail Grocery | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Raymond E. Atkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Barbara Ann Jameson | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Barbara Ann Gardner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5311 Accokeek Rd. Brandywine, MD 20613 | | | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington National Cemetery 12/18/92 Suitland, MD | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
4308 Suitland Rd. Marshall's Funeral Home, Inc. Suitland, MD 20746 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRAORAL GUNSHOT WOUND, CONTACT
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
12 14 1992 | | 28b. TIME OF INJURY
7:10 P | | 28c. INJURY AT WORK?
1 YES 2 NO | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
at home | | 28d. DESCRIBE HOW INJURY OCCURRED
Self inflicted wound | | | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
9323 Alcona Street | | | | | | | | | |
| 29. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12 15 1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLLE, JR, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 18 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed and signed by the attending physician and completed filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37353

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
THELMA MAY ANDRE | | | | 2. DATE OF DEATH
MONTH 12 DAY 11 YEAR 92 | | 3. TIME OF DEATH
8:30 P M | |
| 4. SOCIAL SECURITY NUMBER
579-01-8581 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 18, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number)
5606 35th Place | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hyattsville | | 9c. COUNTY OF DEATH
Prince Georges | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5606 35th Place | | | | 10f. ZIP CODE
20782 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) ----- | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
----- Book Binding | | 16b. KIND OF BUSINESS/INDUSTRY
Gov't Printing Office | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Millard w. Wheeler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Elizabeth Franklin | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Eugene G. Bourne, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7315 Longbranch Drive New Carrollton, Md. 20784 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill 12-16-1992 | | OATE | | 20c. LOCATION — City or Town, State
Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack D. Friend</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gaschs Sons
Funeral Home, Hyatts. Md. 4739 Balt. Ave.
20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Cardiac Arrest</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. <i>Diabetes mellitus</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. <i>Coronary Heart Failure</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. <i>Hypertension</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>ao</i> | | | | 29c. LICENSE NUMBER
D34Y22 | | 29d. DATE SIGNED (Month, Day, Year)
► 12-15-1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Vicken K. Poochikian 5632 Annapolis Road, Bladensburg, Maryland 20710 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 17 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Gina Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37354

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY M. ALLWINE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Dec. 17, 1992 | | 3. TIME OF DEATH
10 15 P M | |
| 4. SOCIAL SECURITY NUMBER
578-09-7993 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 16, 1901 | |
| 8. BIRTHPLACE (State or Foreign Country)
Greensboro, Md. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Greenbelt Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Greenbelt | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Md. | | | |
| 10b. COUNTY
Prince George's | | | | 10c. CITY, TOWN OR LOCATION
Cottage City | | | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4000 Cottage Terrace | | | |
| 10f. ZIP CODE
20722 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Manager | | 16b. KIND OF BUSINESS/INDUSTRY
Laundry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Archibold V. Replogle | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ella Rennings | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mildred A. Wagner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1321 Vandine St., Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 12/21/92 | | 20c. LOCATION — City or Town, State
Brentwood, Md. 20722 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>H. Constantine Gasch</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home
4739 Baltimore Ave., Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary Arrest</i> | | | | | | | |
| b. <i>Sepsis</i> | | | | | | | |
| c. <i>Coronary Artery Disease</i> | | | | | | | |
| d. <i>Carcinoma of the Vagina</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Coronary Artery Disease</i>
<i>Carcinoma of the Vagina</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S. Trifoglio MD</i> | | | | 29c. LICENSE NUMBER
D37934 | | 29d. DATE SIGNED (Month, Day, Year)
12/18/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S. Trifoglio MD 7500 Greenway Ctr Drive Greenbelt MD 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37355

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Kenneth R. Appold | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 18, 1992 | | 3. TIME OF DEATH
2:00A M | |
| 4. SOCIAL SECURITY NUMBER
712-05-1860 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
81 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
June 12, 1911 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | |
| 9a. FACILITY NAME (If not institution, give street and number)
Fox Chase Rehabilitation & Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Kensington | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
10404 Ewell Avenue | | | | 10f. ZIP CODE
20895 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Oil Service Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY
British Petroleum | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Horace Appold | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Hazel Reichard | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William E. Appold | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10404 Ewell Avenue, Kensington, Maryland 20895 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 12/21/92 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | | 20d. DATE
12/21/92 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Daniel E. Perry. M00803 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary artery disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
1 yr |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Myron L. Lenkin, MD | | | | 29c. LICENSE NUMBER
D06674 | | 29d. DATE SIGNED (Month, Day, Year)
12-18-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MYRON L. LENKIN, MD. 2309 SHOREFIELD RD, WHEATON, MD 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | 32. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37356

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JEANNETTE LINDE AARONSON | | | | 2. DATE OF DEATH
MONTH DECEMBER DAY 17 YEAR 1992 | | 3. TIME OF DEATH
7:00 AM | |
| 4. SOCIAL SECURITY NUMBER
579-60-3305 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10-14-10 | |
| 9a. FACILITY NAME (If not institution, give street and number)
622 WALNUT AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ROSE HAVEN | | 9c. COUNTY OF DEATH
ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
FLORIDA | | 10b. COUNTY
PALM BEACH | | 10c. CITY, TOWN OR LOCATION
PALM BEACH | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
354 S. OCEAN BLVD. | | | | 10f. ZIP CODE
33480 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
DOMESTIC | | | |
| 17. FATHER'S NAME (First, Middle, Last)
LOUIS ROSENBERG | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HENRIETTA SCHLOSSBERG | | | |
| 19a. INFORMANT'S NAME (Type/Print)
BARRETT M. LINDE (SON) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3824 KLINGLE PLACE, N.W. - WASHINGTON, D.C. 20016 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
ADAS ISRAEL CONG. CEMETERY | | DATE
12/20 | | 20c. LOCATION — City or Town, State
WASHINGTON, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Gay M. J. J. J.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC PHEOCHROMOCYTOMA

Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

Approximate Interval Between Onset and Death
59V | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Lewis H. T. T. T.</i> | | | | 29c. LICENSE NUMBER
D00692 | | 29d. DATE SIGNED (Month, Day, Year)
12/17/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LEWIS H. T. T. T. 1145-19TH ST NW WASHINGTON DC 20036 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 is marked, or item 28 is marked, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
KEITH ANDERSON | | | | 2. DATE OF DEATH
MONTH 12 DAY 09 YEAR 92 | | 3. TIME OF DEATH
9:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER
578-02-0773 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
22 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9/29/70 | |
| 8. FACILITY NAME (If not institution, give street and number)
CALVERT MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
PRINCE FREDERICK | | 9c. COUNTY OF DEATH
CALVERT COUNTY | |
| 10a. STATE
MD | | | | 10b. COUNTY
Calvert | | 10c. CITY, TOWN OR LOCATION
Huntingtown | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
125 Thomas Gantt Rd. | | | |
| 10f. ZIP CODE
20639 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Lineman /Military Police National Guard | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Kenneth Anderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Glinda Copeland Anderson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Glinda Copeland | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
125 Thomas Gantt Rd. Huntingtown, MD 20639 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veteran's | | 20c. DATE
12/15/92 | | 20d. LOCATION — City or Town, State
Cheltenham, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Glinda Copeland</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Hodges and Edwards
3720 Old Silver Hill Rd. Suit. MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple myeloma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
12-09-1992 | | 28b. TIME OF INJURY
7:54P.M. | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
DRIVE IN TRUCK /AUTO IMPACT | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
ON ROAD | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
RT. 4 & RT. 260 | | 28g. COUNTY
DUNKIRK CALVERT COUNTY | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Monte H. Hall</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12-10-1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Monte H. Hall 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 11 1992 | | 32. REGISTRAR'S SIGNATURE
<i>Johanna Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ranando P. Branch | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 07 1992 | | 3. TIME OF DEATH
8:40P. M | | | | | |
| 4. SOCIAL SECURITY NUMBER
579-64-0228 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
19 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Sept. 24, 1973 | | 8. BIRTHPLACE (State or Foreign Country)
Wash. D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Prince Georges Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | | 9c. COUNTY OF DEATH
Prince Georges | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Oxon Hill | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
828 Maury Ave | | | | 10f. ZIP CODE
20745 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
None | | | 16b. KIND OF BUSINESS/INDUSTRY
None | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Paul Thornes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rhoda Branch | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Rhoda Branch - Mother | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
828 Maury Ave. Oxon Hill, Md. 20745 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park 12/14 | | | 20c. LOCATION — City or Town, State
Landover, Md. | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
F. Bernard Hunt | | | | 22. NAME AND ADDRESS OF FACILITY
Hunt Funeral Home
2801 7th St. N.E. Wash. D.C. 20017 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUNDS TO BACK
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year)
12/07/1992 | | 28b. TIME OF INJURY
7:29P.M. | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
Subject Shot | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Yard | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
804 Maury Ave. Oxon Hill | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/08/1992 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLIE, JR MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 16 1992 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28b is marked, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37359

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
FLORENCE C. BUGG | | | | 2. DATE OF DEATH
MONTH 12 DAY 07 YEAR 92 | | 3. TIME OF DEATH
12:50 AM | |
| 4. SOCIAL SECURITY NUMBER
578-54-3177 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
52 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year) 2/21/40 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash., D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
Md. | | 10b. COUNTY
P.G. | |
| 10c. CITY, TOWN OR LOCATION
Landover | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
6902 Flagstaff St. | |
| 10f. ZIP CODE
20785 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9th College (1-4 or 5+) School Bus Driver | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
School Bus Driver | | | | 16b. KIND OF BUSINESS/INDUSTRY
County Gov't. P.G. School System | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Randolph Brooks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Christine Alston | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jerome Bugg | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6608 Greig St. # 203, Seat Pleasant, Md. 20743 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park 12/12/92 | | | |
| 20c. LOCATION — City or Town, State
Landover, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Larry H. Pratt</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E. | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer with metastasis to the bone
DUE TO (OR AS A CONSEQUENCE OF):
b. Renal insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
c. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
d. Upper Gastrointestinal bleeding

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Myocardial infarction | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Moustafa Shamma, MD, PhD | | | |
| 29c. LICENSE NUMBER
D43690 | | | | 29d. DATE SIGNED (Month, Day, Year)
12/9/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MOUSTAFA SHAMMA, 3001 Hospital Dr., Cheverly, MD 20785 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 16 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37360

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Bernadette Baranska | | | | 2. DATE OF DEATH
December 10 1992 | | | | 3. TIME OF DEATH
3:20PM | |
| 4. SOCIAL SECURITY NUMBER
219-62-2732 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
02-11-1934 | | 8. BIRTHPLACE (State or Foreign Country)
Ireland | |
| 9a. FACILITY NAME (If not institution, give street and number)
Lot 49 Waysons Trailer Court | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lothian | | | | 9c. COUNTY OF DEATH
Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Lothian | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
Lot 49 Waysons Trailer Court | | | | 10f. ZIP CODE
20711 | | 10g. CITIZEN OF WHAT COUNTRY?
Ireland | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Assistant Manager/Hostess | | 16b. KIND OF BUSINESS/INDUSTRY
Wayson's Restuarant | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Edward Anderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Genevieve Hamilton | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
John P. Baranska, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 A-F | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lakemont Mem. Grdns. | | DATE
12-15-92 | | 20c. LOCATION — City or Town, State
Davidsonville, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Joseph Baranski</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd., Clinton, Md. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CARDIAC ARREST
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. CARDIAC ARRHYTHMIA
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | | c. CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | | d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Jose L. Puebla-Tarilonte</i>
COL USAF MC | | | | 29c. LICENSE NUMBER
9386C | | 29d. DATE SIGNED (Month, Day, Year)
December 11-1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)
Malcolm Grow Medical Center | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 17 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randell</i> | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37361

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Charles R. Burton, Sr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 16, 1992 | | 3. TIME OF DEATH
7:15A | |
| 4. SOCIAL SECURITY NUMBER
577-28-9201 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
JULY 15, 1921 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
8433 Old Marlboro Pike | | | |
| 9b. CITY, TOWN OR LOCATION OF DEATH
Upper Marlboro | | | | 9c. COUNTY OF DEATH
Prince George's | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Upper Marlboro | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8433 Old Marlboro Pike | | | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
1941-1945 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2+ | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Electrician | | 16b. KIND OF BUSINESS/INDUSTRY
Department of Defense | |
| 17. FATHER'S NAME (First, Middle, Last)
John Henry Burton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Katherine Repp | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Irene Burton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10a.-10f. | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
12-18-92
Md. State Veterans Cemetery | | 20c. LOCATION — City or Town, State
Cheltenham, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Road
Clinton, Md. 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | Hypertensive arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cancer of the liver
Hepatic encephalopathy | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D12879 | | 29d. DATE SIGNED (Month, Day, Year)
Dec 16, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALFONSO VALLE MD, 10701 TRAFALGAR DR, LARGO, MD 20774 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 17 1992 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37362

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ETHEL IRENE BLOSK | | | | 2. DATE OF DEATH
MONTH 12 DAY 06 YEAR 1992 | | 3. TIME OF DEATH
3:40 P M | |
| 4. SOCIAL SECURITY NUMBER
579-07-3716 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9/05/1918 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Doctors' Community Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
5600 Queens Chapel Road | | | | 10f. ZIP CODE
20782 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th Grade
College (1-4 or 5+) ----- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Monroe Conrad | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Cora King | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joan E. Blosk | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5600 Queens Chapel Road, Hyattsville, MD 20782 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 12/09/92 | | 20c. LOCATION — City or Town, State
Suitland, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack D. Friend</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary arrest</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Under Heart Attack</i>
<i>Adenocarcinoma</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> P <input type="checkbox"/> A <input type="checkbox"/> N | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>M. J. Tolson</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
12/8/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ITEMS: 23 PART I, 27 PER MEO G-695 1/11/93 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|-----------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
A RYN W. BOWYER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 14 92 | | 3. TIME OF DEATH
6:03 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER
213-37-5248 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS
4 13 | | 7. DATE OF BIRTH
(Month, Day, Year)
07 31 1992 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | | | 9c. COUNTY OF DEATH
Baltimore | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Forestville | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER
6601 Hil-Mar Drive | | | | 10f. ZIP CODE
20747 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
N/A | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
N/A | | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Whitney James Hamilton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ROLSHELL BOWYER | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Rolshell Bowyer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6601 Hil-Mar Drive Forestville, MD 20747 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Suburban Crematory 12-17 | | | 20c. LOCATION — City or Town, State
Silver Spring, MD | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Kimberly C. Buscoe</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B.JENKINS FUNERAL HOME
7474 LANDOVER ROAD LANDOVER, MD 20785 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA COMPLICATING CONGENITAL CHEST DEFORMITY
DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Mario F. Gole, Jr. MD</i> | | | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/15/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLE, JR. MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Johanna Davidson-Randall</i> | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CLAIRE N BROWN, SR | | | | 2. DATE OF DEATH
MONTH 12 DAY 21 YEAR 92 | | 3. TIME OF DEATH
4:40 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER
579-03-3705 | | 5. SEX
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
3/21/15 | | 8. BIRTHPLACE (State or Foreign Country)
W. Va. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | | | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
P.G. | | 10c. CITY, TOWN OR LOCATION
Chapel Oaks | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
1217 Nye St. | | | | 10f. ZIP CODE
20743 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12)
10th | | | | College (1-4 or 5 +)
Trackman | | | | Railroad | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Walter N. Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Amanda McCann | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Claudia M. Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as # 10 above | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park 12/28/92 | | DATE
Landover, Md. | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Gary W. Pratt | | | | 22. NAME AND ADDRESS OF FACILITY
H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiomyopathy Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {
Respiratory insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
Adult Respiratory Distress Syndrome
DUE TO (OR AS A CONSEQUENCE OF):
Sepsis | | | | | | | | Approximate interval Between Onset and Death
1d
7d
7d
10d | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Robert H. [Signature] | | | | | | 29c. LICENSE NUMBER
032403 | | 29d. DATE SIGNED (Month, Day, Year)
12/28/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Walter N. Brown Jr. Hospital, Cheverly, Md | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 1992 | | | | 32. REGISTRAR'S SIGNATURE
Johanna Davidson-Randell | | | | | | | |

and,

x

92 37365

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILFRED ARTHUR BOUCHARD | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 19, 1992 | | 3. TIME OF DEATH
8:16 A M | |
| 4. SOCIAL SECURITY NUMBER
006-18-7542 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
OCT 21, 1923 | | 8. BIRTHPLACE (State or Foreign Country)
Maine | |
| 9a. FACILITY NAME (If not institution, give street and number)
MALCOLM GROW USAF MEDICAL CENTER | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Camp Springs | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
Maryland | | | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Upper Marlboro | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 10e. STREET AND NUMBER
4900 Colonel Contee Place | | | |
| 10f. ZIP CODE
20772 | | | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Captain | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Air Force | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Bouchard | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Phoebe Chaisson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Vivian B. Bouchard | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 A-F | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arlington National Cem. 12/23/92 | | 20c. LOCATION — City or Town, State
Arlington Virginia | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | |
| 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd Clinton Md 20735 | | | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. SQUAMOUS CELL CANCER, MOUTH, THROAT
DUE TO (OR AS A CONSEQUENCE OF):

b. SEVER EMPHYZEMA
DUE TO (OR AS A CONSEQUENCE OF):

c. RESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):

d. BLADDER AND PROSTATE CANCER | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | | | 29c. LICENSE NUMBER
--- | | 29d. DATE SIGNED (Month, Day, Year)
DEC 19, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HENRY E. HOLLOWAY, MAJ, USAF, MC | | | | | | MALCOLM GROW USAF MEDICAL CENTER
ANDREWS AFB, MD 20331-5300 | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21205-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the funeral director or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 52



92 37366

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>HELEN G. Burke</i> | | | | 2. DATE OF DEATH
MONTH <i>12</i> DAY <i>22</i> YEAR <i>92</i> | | 3. TIME OF DEATH
<i>6:10A</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>578-05-8069</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>78</i> YRS. | | 7. DATE OF BIRTH
MONTH <i>3</i> DAY <i>10</i> YEAR <i>14</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Wash., D.C.</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Bradford Oaks Nursing Home</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Clinton</i> | |
| 9c. COUNTY OF DEATH
<i>Prince George's</i> | | | | 10a. STATE
<i>Md.</i> | | 10b. COUNTY
<i>Prince George's</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Upper Marlboro</i> | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>4907 Colonel Beall Place</i> | |
| 10f. ZIP CODE
<i>20772</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Admin. Assistant</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Cap Telephone</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>John S. Meade</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Maude V. Pearson</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Patricia M. Fontaine</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>Same as 10a.-10f.</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Ft. Lincoln Cemetery</i> | | 20c. LOCATION — City or Town, State
<i>Brentwood, Md.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Norman W. [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Lee Funeral Home, Inc.
6633 Old Alexander Ferry Road
Clinton, Md. 20735</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Arrest</i>
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
a. <i>Septum</i>
b. <i></i>
c. <i></i>
d. <i></i> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dehydration, Dehydration, Foley catheter</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <i></i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Michael D. Levine</i> | | 29c. LICENSE NUMBER
<i>D24945</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>December 22, 1992</i> | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Dr. Michael D. Levine, MD., 7801 Old Branch Ave., Clinton, MD. 20735</i> | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 23 1992</i> | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Queenie Brown | | | | 2. DATE OF DEATH
MONTH 12 DAY 19 YEAR 1992 | | 3. TIME OF DEATH
8:05 P.M. | |
| 4. SOCIAL SECURITY NUMBER
249-38-1621 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
1-21-21 | |
| 8a. FACILITY NAME (If not institution, give street and number)
Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Fethesda | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5721 Grosevenor Lane | | | | 10f. ZIP CODE
20814 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 3rd | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Jim Mack | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Emma Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
738 Harvard Street N.W., Washington, D.C. 20001 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. DATE
12-26 | | 20d. LOCATION — City or Town, State
Landover, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
J. P. Marshall | | | | 22. NAME AND ADDRESS OF FACILITY
Marshall's Funeral Home Inc.
4217 9th Street, N.W., Washington, D.C. 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CARDIOVASCULAR DISEASE
Cardiovascular Disease. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Recurrent aspiration pneumonia, and urinary tract infections; Peripheral vascular disease. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John Davidson MD | | | | 29c. LICENSE NUMBER
D08546 | | 29d. DATE SIGNED (Month, Day, Year)
12-20-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John Tauber 8218 Wisconsin Ave Bethesda Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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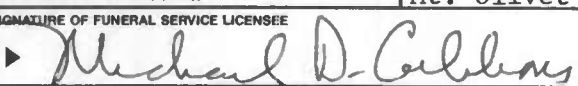
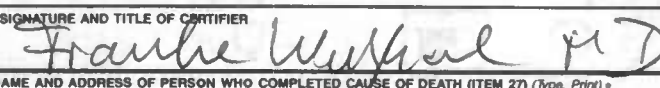
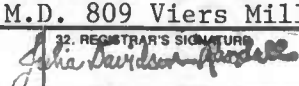
95 0128

CONFIDENTIAL

92 37368

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Dolores Alberta Berry | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Dec. 23, 1992 | | 3. TIME OF DEATH
7:30 A. M. | |
| 4. SOCIAL SECURITY NUMBER
216-46-9348 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 23, 1900 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Rockville Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rockville | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | |
| 10c. CITY, TOWN OR LOCATION
Rockville | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
4 Sherry Court | |
| 10f. ZIP CODE
20852 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
D.C. Public School System | |
| 17. FATHER'S NAME (First, Middle, Last)
Salvadore Sanders | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alberta "UNKNOWN" | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William S. Nolte | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Sherry Ct. Rockville, MD 20852 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery | | 20c. LOCATION — City or Town, State
12/28 Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
De Vol Funeral Home
10 E. Deer Park Dr., Gaithersburg, MD 20877 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular accident | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| recurrent pneumonia | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

Frauke Westphal M.D. | | | | 29c. LICENSE NUMBER
D19785 | | 29d. DATE SIGNED (Month, Day, Year)
Dec. 23, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Frauke Westphal, M.D. 809 Viers Mill Rd. Rockville, Maryland 20851 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 '92 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37369

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HENRY B. BRADY | | | | 2. DATE OF DEATH
MONTH 12 DAY 17 YEAR 92 | | | | 3. TIME OF DEATH
7:08A.M. | |
| 4. SOCIAL SECURITY NUMBER
578128919 | | 5. SEX
1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
2-03-20 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
TAKOMA PARK, MD. | | | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
SILVER SPRING | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
717 GIST AVENUE | | | | 10f. ZIP CODE
20910 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
CONSTRUCTION WORKER | | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
HENRY BERNARD BRADY, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MAUDE GIBBONS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JUNE MARIE BRADY (WIFE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
717 GIST AVENUE SILVER SPRING, MARYLAND 20910 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
FORT LINCOLN CEMETERY 12/21 | | | | 20c. LOCATION — City or Town, State
BRENTWOOD, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James S. Doolley</i> | | | | 22. NAME AND ADDRESS OF FACILITY
FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | |
| a. 100% (R) pneumothorax
DUE TO (OR AS A CONSEQUENCE OF):
b. Severe Bullous Emphysema
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic cigarette abuse
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | | |
| Approximate Interval Between Onset and Death
months
years
Decades | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Norton Elson MD</i> | | | | 29c. LICENSE NUMBER
D20362 | | | | 29d. DATE SIGNED (Month, Day, Year)
12/18/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Norton Elson 6525 Belcrest Rd Hyattsville MD 20782 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Rodell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows an injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37370

| | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
IDA BOBB | | | | 2. DATE OF DEATH
MONTH 12 DAY 19 YEAR 1992 | | | | 3. TIME OF DEATH
8:25 A.M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
577-48-3644 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | | 7. DATE OF BIRTH
(Month, Day, Year)
NOV 26 1902 | | 8. BIRTHPLACE (State or Foreign Country)
RUSSIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SUBURBAN HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | | | | | | 9c. COUNTY OF DEATH
Montgomery | | | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
MONTGOMERY | | | | 10c. CITY, TOWN OR LOCATION
SILVER SPRING | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
1220 EAST-WEST HIGHWAY #1024 | | | | | | 10f. ZIP CODE
20910 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES _____ | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: _____ | | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
RETAIL-OWNER | | | | 16b. KIND OF BUSINESS/INDUSTRY
LIQUOR STORE | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
SAMUEL BRODER | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ANNA (UNKNOWN) | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JACK BOBB | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4601 NORTH PARK AVE. #1209 BETHESDA, MD. 20915 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. LEBANON CEMETERY | | | | OATE 12/21 | | 20c. LOCATION — City or Town, State
ADELPHI, MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Frank G. Stone</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
DANZANSKY-GOLDBERG MEMORIAL CHAPELS
1170 ROCKVILLE PIKE ROCKVILLE, MD. 20852 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RIGHT BUNDLE BRANCH BLOCK, SEVERE AORTIC STENOSIS, MITRAL REGURGITATION, GASTROENTERITIS, HYPERTENSION, SUPRARENAL CALCULI. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M _____ | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. [Signature]</i> , MD | | | | | | 29c. LICENSE NUMBER
D26571 MD | | | | 29d. DATE SIGNED (Month, Day, Year)
12/19/92 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
IRVING MIZUS, MD 5413 CEDAR LANE #206C BETHESDA, MD 20814 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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92 37371

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Clinton Berry | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12- 17-1992 | | 3. TIME OF DEATH
12:35 A M | |
| 4. SOCIAL SECURITY NUMBER
248-14-2446 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11-16-1917 | |
| 8. BIRTHPLACE (State or Foreign Country)
S. Carolina | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Grovenor Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Virginia | | 10b. COUNTY
Arlington | | 10c. CITY, TOWN OR LOCATION
Alexandria | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2685 Arlington Drive, | | | | 10f. ZIP CODE
22306 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Nursery Sch. Proprietor | | 16b. KIND OF BUSINESS/INDUSTRY
Self | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Berry | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Selina ?. | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ms Lisa Berry (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2685 Arlington Dr, Alexandria, Va | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. LOCATION — City or Town, State
12/23 Alexandria, Va | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George A. Anderson</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Snowden Funeral Home P.A., 20850
246 N. Washington St, Rockville, Md | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebro Vascular Accidents, Multiple
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Peripheral Vascular Insufficieny

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Insufficieny | | | | | | | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL:
<input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER:
<input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John Tauber MD</i> | | | | 29c. LICENSE NUMBER
D08546 | | 29d. DATE SIGNED (Month, Day, Year)
12-17-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John Tauber 8218 Wisconsin Ave, Bethesda, Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

92 37372

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RICHARD BROWN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 13, 1992 | | | | 3. TIME OF DEATH
9:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER
578-05-2528 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
December 31, 1911 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | |
| 9a. FACILITY NAME (If not institution, give street and number)
Harbour Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Landover | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1209 Vermont Ave. | | | | 10f. ZIP CODE
20785 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Driver | | | | 16b. KIND OF BUSINESS/INDUSTRY
Liner Service | |
| 17. FATHER'S NAME (First, Middle, Last)
Samuel Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mamie Hardy | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Patricia Ann O'Leary | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25 Fairmont Pl. Indian Head, MD 20640 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 12/17/92 Brentwood, MD | | | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
4308 Suitland Rd
Marshall's Funeral Home, Inc. Suitland, MD 20746 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| a. INOOPERABLE CARCINOMA OF FLOOR OF MOUTH AND TONGUE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 46 days | |
| b. SUBMANDIBULAR ABSCESS
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> MD | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
DECEMBER 13, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOSHUA IMPERIO 3001 S. HANOVER STREET, BALTIMORE, MD 21225 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 15 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37373

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LILLIAN ELIZABETH BROOKS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 4, 1992 | | 3. TIME OF DEATH
5:35 p.m. | |
| 4. SOCIAL SECURITY NUMBER
262-20-7533 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Sep 11, 1923 | |
| 9a. FACILITY NAME (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LANHAM SEABROOK | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S CO. | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
New Carrollton, | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6207 87th Avenue | | | | 10f. ZIP CODE
20784 | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
6th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY
Private | |
| 17. FATHER'S NAME (First, Middle, Last)
John Wesley Taylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ruth Nathan | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Amelia Brooks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6207 87th Avenue, New Carrollton, Maryland 20784 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Dade Memorial Cemetery | | DATE
12/9/92 | | 20c. LOCATION — City or Town, State
Miami, Florida | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Johnson & Jenkins Inc.
716 Kennedy Street, NW, Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cardio-respiratory failure</i>
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>renal failure</i>
c. <i>obstructive uropathy</i>
d. <i>dehydrated renal cortex</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>hypertension</i>
<i>coronary atherosclerosis</i>
<i>myocardial infarction</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 25. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OCA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D01499 | | 29d. DATE SIGNED (Month, Day, Year)
12/1/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Lewis Hillard Dennis M.D., 6201 Greenbelt Rd., College Park, Md. 20740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 9 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37374

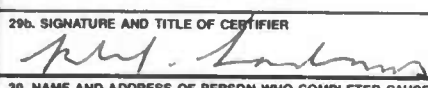
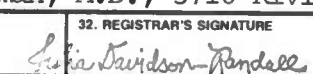
1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Alma Anna Bumgardner | | | | 2. DATE OF DEATH
MONTH 12 DAY 04 YEAR 92 | | 3. TIME OF DEATH
9:21A M | |
| 4. SOCIAL SECURITY NUMBER
577-34-9911 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH
MONTH 04 DAY 09 YEAR 06 | |
| 8. BIRTHPLACE (State or Foreign Country)
West Virginia | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Southern Maryland Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Clinton | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Washington, D. C. | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
822 A Street, S.E. | | | | 10f. ZIP CODE
20003 | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. of A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
Navy Yard
U. S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George Albert Wickham | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Parrish | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Janet L. Elliott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5240 Kenstan Drive, Temple Hills, Maryland 20748 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Wash. Nat'l Cemetery 12-07-92 | | 20c. LOCATION — City or Town, State
Suitland, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd., Clinton, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic and hemorrhagic stroke
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
6 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D18055 | | 29d. DATE SIGNED (Month, Day, Year)
12/4/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ronald B. Landman, M.D., 3710 Riviera Street, Temple Hills, Maryland 20748 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37375

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DAVID F. BAUER | | | | 2. DATE OF DEATH
MONTH 12 DAY 01 YEAR 92 | | 3. TIME OF DEATH
11:16 A M | |
| 4. SOCIAL SECURITY NUMBER
578-36-7228 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
62 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
August 30, 1930 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY, | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION
Harwood | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
1244 Vintage Drive | |
| 10f. ZIP CODE
20776 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Korean Conflict | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
production planner | | 16b. KIND OF BUSINESS/INDUSTRY
Printing Company | |
| 17. FATHER'S NAME (First, Middle, Last)
James M. Bauer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Violet E. Purcell | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Karen L. Bauer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
318 S. Detroit St. #408, Los Angeles, CA 90036 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 12/5/92 | | 20c. LOCATION — City or Town, State
Suitland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
4308 Suitland Rd.
Marshall's Funeral Home, Inc. Suitland, MD 20746 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
b. ARRHYTHMIA
DUE TO (OR AS A CONSEQUENCE OF):
c. coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Repair of Abdominal Aneurysm Right Renal Artery Aneurysm and Right Iliac Artery Aneurysm 11/30/92 | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D23586 | | 29d. DATE SIGNED (Month, Day, Year)
12/2/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BRIAN S. BAYLY MD 7223 Honor Pkwy Greenbelt Md 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 09 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M.E., Dr. Valle Notified & Released

25 31312

9

92 37376

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Thomas BREWER | | | | 2. DATE OF DEATH
MONTH 12 DAY 6 YEAR 1992 | | 3. TIME OF DEATH
1610 M | |
| 4. SOCIAL SECURITY NUMBER
212-64-4587 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
37 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
04-28-55 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
LELAND MEMORIAL PARK | | 9b. CITY, TOWN OR LOCATION OF DEATH
HYATTSVILLE | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
MARYLAND | | | |
| 10b. COUNTY
PRINCE GEORGE'S | | | | 10c. CITY, TOWN OR LOCATION
HYATTSVILLE | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4603 BURLINGTON RD. | | | |
| 10f. ZIP CODE
20781 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) LABORER | | | | 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
LABORER | | | |
| 16a. DECEDENT'S USUAL OCCUPATION | | | | 16b. KIND OF BUSINESS/INDUSTRY
PVT. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
THOMAS BREWER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CLEO BREWER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CLEO BREWER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4603 BURLINGTON RD. HYATTSVILLE, MD20781 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)
HARMONY MEMORIAL PARK 12-10 | | 20c. LOCATION — City or Town, State
LANDOVER, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Thawana L. Braxton | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME | | 22. NAME AND ADDRESS OF FACILITY
7474 LANDOVER RD. LANDOVER, MD20785 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → AIDS

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

CHRONIC RENAL FAILURE
MYOCARDIAL INFARCTION | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28a. DATE OF INJURY | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
A. DASHOT | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
12/6/92 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
A. DASHOT, M.D., 7207 HANOVER PARK Way #A, GREENBELT, MD 20770 | |
| 31. DATE FILED (Month, Day, Year)
DEC 9 1992 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25 03030

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9

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37377

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CATHERINE V. BOONE | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 4 92 | | 3. TIME OF DEATH
11:55 AM | |
| 4. SOCIAL SECURITY NUMBER
213-40-9798 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
52 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year)
03-31-40 | | 8. BIRTHPLACE (State or Foreign Country)
WASH., DC | | 9. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION
LANDOVER | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1230 CAPITOL VIEW DRIVE | | 10f. ZIP CODE
20785 | |
| 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
TAX REVENUE OFFICER | | 16b. KIND OF BUSINESS/INDUSTRY
GOVT. | | 17. FATHER'S NAME (First, Middle, Last)
VINCENT E. BOONE, SR. | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
KATIE L. QUEEN | | 19a. INFORMANT'S NAME (Type/Print)
ALAN SAMPSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
233 KENON DR. DANVILLE, VA. 24540 | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK 12-10 | | 20c. LOCATION — City or Town, State
LANDOVER, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Muawana L. Braxton | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME
7474 LANDOVER RD. LANDOVER, MD 20785 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Large intracranial bleed
DUE TO (OR AS A CONSEQUENCE OF):
b. Arterio-Venous malformation
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
4 days | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28c. INJURY AT WORK?
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Moustafa Shamma, MD, PhD | | 29c. LICENSE NUMBER
D43690 | |
| 29d. DATE SIGNED (Month, Day, Year)
12/6/92 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MOUSTAFA SHAMMA, MD, PhD, 3001 HOSPITAL DR, CHEVERLY, MD 20785 | | 31. DATE FILED (Month, Day, Year)
DEC 07 1992 | |
| 32. REGISTRAR'S SIGNATURE
Sasha Davidson-Randall | | | | | |

92 37378

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
LEON BARNETT, SR. | | | | 2. DATE OF DEATH
MONTH 12 DAY 4 YEAR 92 | | 3. TIME OF DEATH
6:28 PM | |
| 4. SOCIAL SECURITY NUMBER
216-50-7556 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
43 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 2, 1949 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash., D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Prince George's | | | | 10c. CITY, TOWN OR LOCATION
Camp Springs | | | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
5210 Carswell Avenue | | | |
| 10f. ZIP CODE
20746 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Property Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Government | |
| 17. FATHER'S NAME (First, Middle, Last)
Winfield Barnett | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ester E. Chapman | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Winfield Barnett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9603 Tiberias Dr., Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park 12-8 | | 20c. LOCATION — City or Town, State
Landover, Maryland | | 20d. DATE
12-8 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Shawana L. Braxton | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. Jenkins Funeral Home
7474 Landover Rd, Landover, Md. 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gram positive sepsis - Staphylococcus
DUE TO (OR AS A CONSEQUENCE OF):
b. Multiple Cerebral Infarct / Cerebro
DUE TO (OR AS A CONSEQUENCE OF):
c. Upper gastrointestinal bleed
DUE TO (OR AS A CONSEQUENCE OF):
d. Residual Left Lower lobe infiltrate | | | | | | | Approximate Interval Between Onset and Death
5 days |
| PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Diabetes Mellitus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. DATE SIGNED (Month, Day, Year)
12/5/92 | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
John M. Davidson | | | |
| 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John M. Davidson MD 8200 Corporate Drive Landover MD 20785 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 07 1992 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37379

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ALBERTA MARION BARLOW | | | | 2. DATE OF DEATH
MONTH 12 DAY 7 YEAR 1992 | | 3. TIME OF DEATH
5:05 P. M. | |
| 4. SOCIAL SECURITY NUMBER
577-36-2123 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 14, 1928 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Washington Adventist Hosp | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Takoma Park | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Takoma Park | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
6405 Alleghany Avenue | | | |
| 10f. ZIP CODE
20902 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George Amos Libby | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marion E. Williams | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dianne Jewett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10019 Greenbelt Rd., #103, Lanham, Maryland 20706 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Geo Wash Univ Med Sch 12-09-92 | | 20c. LOCATION — City or Town, State
Washington, D.C. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Columbia Mortuary Services, Inc.
225 Missouri Ave, NW Washington, D.C. 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
2 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> M.D. | | | | 29c. LICENSE NUMBER
D 16540 | | 29d. DATE SIGNED (Month, Day, Year)
12-7-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JANE A. RORAN JR M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 11 1992 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37380

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Mary</i> | | | | 2. DATE OF DEATH
MONTH <i>12</i> DAY <i>22</i> YEAR <i>92</i> | | | | 3. TIME OF DEATH
<i>11:25</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>220-26-2624</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>64</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>12/2/28</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>New York</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Prince Georges Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Cheverly</i> | | | | 9c. COUNTY OF DEATH
<i>Prince Georges</i> | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Howard</i> | | 10c. CITY, TOWN OR LOCATION
<i>Ellicott City</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>4049 Crescent Road</i> | | | | 10f. ZIP CODE
<i>21042</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Homemaker</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Harold Fraser Watson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Sarah Keys</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Mary Jane Bien</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4049 Crescent Road, Ellicott City, Md. 21042</i> | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>St. John's Cemetery 12/24/92</i> | | | | 20c. LOCATION — City or Town, State
<i>Ellicott City, Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Harry H. Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>HARRY H. WITZKE FUNERAL HOME
4112 Old Columbia Pk., Ellicott City, Md. 21043</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diabetic cerebrovascular renal arterio sclerotic vascular disease</i>
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>August P. Rodriquez MD</i> | | | | | | 29c. LICENSE NUMBER
<i>A21230</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12-22-92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>August P. Rodriquez MD 5009 Rayburn Ct. Cp. Spr. Md 20748</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 28 '92</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37381

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BARBARA A. BORDER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 / 28 / 1992 | | 3. TIME OF DEATH
9:40 P M | |
| 4. SOCIAL SECURITY NUMBER
194 36 0622 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
MAR. 23, 1947 | |
| 8. BIRTHPLACE (State or Foreign Country)
PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALITMORE CITY | |
| 9c. COUNTY OF DEATH
BALITMORE | | | | 10a. STATE
PENNA. | | 10b. COUNTY
YORK | |
| 10c. CITY, TOWN OR LOCATION
YORK TOWNSHIP | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
114 DEW DROP COURT | |
| 10f. ZIP CODE
17403 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH
College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CLERICAL | | 16b. KIND OF BUSINESS/INDUSTRY
PHYSICIANS OFFICE | |
| 17. FATHER'S NAME (First, Middle, Last)
GEORGE J. BRICKNER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
DOROTHY M. MCCLELLAN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
LONNIE A. BORDER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
114 DEW DROP CT. YORK PA 17403 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SUSQUEHANNA MEM. GDS. 12/31/92 | | 20c. LOCATION — City or Town, State
YORK, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert W. Ramsey | | | | 22. NAME AND ADDRESS OF FACILITY
JOHN W. KEEFER FUNERAL HOME, INC.
902 MT. ROSE AVE. YORK, PA 17403 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Liver failure | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): Sclerotic changes | | | | | | | |
| c. STATUS POST LIVER TRANSPLANT | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
12/28/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
600 N. WILHE ST. BALT. MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 05 1993 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

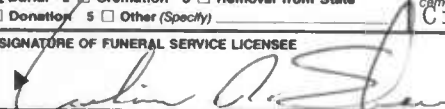
RKD
92-6365-033
UNK. 92-216

92 37382

1 - FOR
STATE
REGISTRAR


STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DEBORAH K. CLARK-NELSON | | | | 2. DATE OF DEATH
MONTH 11 DAY 08 YEAR 92 | | 3. TIME OF DEATH
1:15 P M | | | |
| 4. SOCIAL SECURITY NUMBER
467-19-877 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
37 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
10-10-55 | | 8. BIRTHPLACE (State or Foreign Country)
SHERIDAN LA. | |
| 9a. FACILITY NAME (If not institution, give street and number)
1103 GLENWILLOW DRIVE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SEAT PLEASANT | | | 9c. COUNTY OF DEATH
PRINCE GEORGES | | |
| 10a. STATE
Md | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Riverdale Md. | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
6219 64th Ave # 3 | | | | 10f. ZIP CODE
20737 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
0-12 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Office Work | | 15b. KIND OF BUSINESS/INDUSTRY
Private | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Clark | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Johnnie Lee Howard | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Charles Nelson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6219 64th Ave. Riverdale Md. 20737 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
City Cemetery | | DATE
11/17 | | 20c. LOCATION — City or Town, State
Shreveport, La. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
1425 Maryland Ave. N.E.
Hoffman Funeral Service | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Gunshot wounds of chest and abdomen</u>
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 1103 GLENWILLOW DR. | | | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year)
11-08-92 | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
SUBJECT SHOT | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
IN WOODS | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
1103 GLEN WILLOW DRIVE | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Donald G. Wright MD | | | | 29c. LICENSE NUMBER
OCME | | 29d. DATE SIGNED (Month, Day, Year)
11-09-92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DONALD G. WRIGHT, M.D. 111 PENN STREET, BALTIMORE, MD 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 14 1992 | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the cause of death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37383

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)
Lucia Clark | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-11-92 | | 3. TIME OF DEATH
9:22 AM | |
| 4. SOCIAL SECURITY NUMBER
003-01-8909 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11-24-18 | |
| 8. BIRTHPLACE (State or Foreign Country)
Littleton N.H. | | | | 9a. FACILITY NAME (If not institution, give street and number)
3805 Taylor St. | | 9b. CITY, TOWN OR LOCATION OF DEATH
Chevy Chase | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Md. | | 10b. COUNTY
Montgomery | |
| 10c. CITY, TOWN OR LOCATION
3805 Taylor St. Chevy Chase | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
3805 Taylor St. | |
| 10f. ZIP CODE
20815 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Nurse | | 16b. KIND OF BUSINESS/INDUSTRY
Health Care | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Ernest A. Hutchinson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Mozrall | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Joan Flynn | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3805 Taylor St. Chevy Chase Md. 20815 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Howard University Hosp | | DATE
12/12/92 | | 20c. LOCATION — City or Town, State
Wash. D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Ambrise Bailey | | | | 22. NAME AND ADDRESS OF FACILITY
AAMAN Funeral Service
3605 14th St N.W. Wash D.C. 20016 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Failure
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
Mixed Mullerian Tumor of Uterus,
b. DUE TO (OR AS A CONSEQUENCE OF):
metastatic
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
1wk
1yr | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospice | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Alison Martin MD | | | | 29c. LICENSE NUMBER
18233 | | 29d. DATE SIGNED (Month, Day, Year)
12-11-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Alison Martin MD 5401 Western Ave N.W. Wash.D.C. 20016 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
12-14-92 | | | | 32. REGISTRAR'S SIGNATURE
John Handell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 is marked, injury, or other traumatic event, the medical examiner must be notified at once.

05 11303



92 37384

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Edward J. Culver | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 06 92 | | 3. TIME OF DEATH
3:05 P.M. | |
| 4. SOCIAL SECURITY NUMBER
156-12-4193 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
12/13/17 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Greater Laurel-Beltsville Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | | 9c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
P.G. | | 10c. CITY, TOWN OR LOCATION
Laurel | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
11507 Laurelwalk Dr. | | | | 10f. ZIP CODE
20718 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
10th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Maintenance | | 16b. KIND OF BUSINESS/INDUSTRY
City Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John E. Culver | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Annie Griffin | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Darnell Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as # 10 above | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park 12/12/92 Landover, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Danny M. Grate | | | | 22. NAME AND ADDRESS OF FACILITY
H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | 48 HRS |
| a. ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. RUPTURED ABDOMINAL AORTIC ANEURYSM
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Rene L. Culver MD | | | | | |
| 29c. LICENSE NUMBER
D17502 | | 29d. DATE SIGNED (Month, Day, Year)
12/10/92 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RENE L. CULVER MD | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
14201 LAUREL PARK DR 102A
LAUREL MD 20707 | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 16 1992 | | 32. REGISTRAR'S SIGNATURE
Johanna Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on this certificate must be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows an injury, or other traumatic event, the medical examiner must be notified at once.

92 37385

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Frances Catherine CHESTER | | | | 2. DATE OF DEATH
December 18 1992 | | 3. TIME OF DEATH
8:35 A M | |
| 4. SOCIAL SECURITY NUMBER
578-28-0125 | | 5. SEX
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
March 21, 1925 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | 9a. FACILITY NAME (If not institution, give street and number)
Doctors Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | | 9c. COUNTY OF DEATH
Prince George | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Greenbelt | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
22 Ridge Road #219 | | | | 10f. ZIP CODE
20710 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Paul Leon Shupp | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lucy Linn Riley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Rose Michaud | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
113 Grenada Court, Longmont, Colorado 80501 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Forestville Mem U Meth Ch Cem 12-21-92 | | 20c. LOCATION — City or Town, State
Forestville, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | |
| 22. NAME AND ADDRESS OF FACILITY
Rendon/Hale Lanham Funeral Home
9013 Annapolis Road, Lanham, Maryland 20706 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <i>Sepsis</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Respiratory Failure</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>Anoxic Encephalopathy</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Stroke, Diabetes Mellitus, pre-cardiac tamponade</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D32261 | | 29d. DATE SIGNED (Month, Day, Year)
12-18-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard S. Feldman MD 9500 ANNAPOLIS RD, LANHAM MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37386

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CHARLES B. CLEVELAND | | | | 2. DATE OF DEATH
MONTH 12 DAY 19 YEAR 92 | | 3. TIME OF DEATH
1447 M | |
| 4. SOCIAL SECURITY NUMBER
167-22-0782 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9 19 27 | |
| 9a. FACILITY NAME (If not institution, give street and number)
SUBURBAN HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| 10a. STATE
MD | | | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
CHEVY CHASE | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3702 THORNAPPLE ST | | | |
| 10f. ZIP CODE
20815 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Pharmacist | | 17. KIND OF BUSINESS/INDUSTRY
Pharmacy | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Louis Cleveland | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Elizabeth Killen | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Phyllis M. Cleveland | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3702 Thornapple Street Chevy Chase, MD 20815 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 12/23 | | 20c. LOCATION — City or Town, State
Silver Spring, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Henry J. Saut | | | | 22. NAME AND ADDRESS OF FACILITY
Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, DC 20016 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
ACUTE
INDEF | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year)
12.19.92 | | 28b. TIME OF INJURY
P M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
COLLAPSED MOWING LAWN | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
HO 145 | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
#10 | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Francis C. Mayle | | | | 29c. LICENSE NUMBER
D07099 | | 29d. DATE SIGNED (Month, Day, Year)
12-20-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FRANCIS C. MAYLE 10215 FERNWOOD RD BETHESDA MD 20817-1106 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37387

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Spallen Collins | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12/4/92 | | 3. TIME OF DEATH
2,30 AM | |
| 4. SOCIAL SECURITY NUMBER
217-42-2806 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
01/16/1916 | |
| 9a. FACILITY NAME (If not institution, give street and number)
5614 Hawthorne St. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 9c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
PRINCE George's | | 10c. CITY, TOWN OR LOCATION
Cheverly | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5614 Hawthorne Street | | | | 10f. ZIP CODE
20785 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Spallen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Catherine Heydan | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Francis M. Collins, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5614 Hawthorne St., Cheverly, Md. 20785 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 12/7/92 Clinton, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack R. Friend</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home, 4739 Baltimore Ave., Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA LUNG.
DUE TO (OR AS A CONSEQUENCE OF):

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Rajindra K. Sarin MBBS</i> | | | | 29c. LICENSE NUMBER
D13548 | | 29d. DATE SIGNED (Month, Day, Year)
12.4.92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RAJINDRA K. SARIN 9801 GEORGIA AVENUE SILVER SPRING MD 20912 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 7 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37388

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Bertha, Theresa Currie | | | | 2. DATE OF DEATH
MONTH 12 DAY 3 YEAR 92 | | 3. TIME OF DEATH
11:45 A M | |
| 4. SOCIAL SECURITY NUMBER
579-30-4363 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12-25- 00 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Leland Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Riverdale, | | 9c. COUNTY OF DEATH
Pr. George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Brentwood | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3511 Upshur St, | | | | 10f. ZIP CODE
20722 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) ---- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Sec't | | 16b. KIND OF BUSINESS/INDUSTRY
U. S. Gov't | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Frederick Mack | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sabrina Hepner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert A. Currie | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3511 Upshur St., Brentwood, Md. 20722 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery | | DATE
12/7/92 | | 20c. LOCATION — City or Town, State
Brentwood, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack W. Friend</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home, 4739 Baltimore Ave., Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Congestive Heart failure</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death
<i>yrs</i>
<i>yrs</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Coronary artery disease</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Unides</i> | | | | 29c. LICENSE NUMBER
MD: D28920 | | 29d. DATE SIGNED (Month, Day, Year)
12/4/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
7319 A Hanover Parkway, Greenbelt, MD 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 07 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



9



92 37389

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Florence H. Cushman</i> | | | | 2. DATE OF DEATH
MONTH <i>12</i> DAY <i>6</i> YEAR <i>92</i> | | 3. TIME OF DEATH
<i>10:45 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>505-03-9555</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>79</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>August 9, 1913</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Iowa</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Anne Arundel Medical Center</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Annapolis</i> | |
| 9c. COUNTY OF DEATH
<i>Anne Arundel</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Prince George's</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Hillcrest Heights</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>2103 Keating Street</i> | |
| 10f. ZIP CODE
<i>20748</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>White</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Homemaker & Mother</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>N/A</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Frank J. Halbig</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Caroline Trecker</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Michael A. Cushman</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>100 Pecaniere Pl. Mandeville, La. 70448</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Resurrection Cemetery 12/9/92</i> | | 20c. LOCATION — City or Town, State
<i>Clinton, Maryland</i> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | |
| 22. NAME AND ADDRESS OF FACILITY
<i>George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Maryland 20745</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ventricular arry stoke</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<i>Ischemic heart disease</i>

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Myocardial infarction</i> | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Gerard Blumel MD</i> | | | | 29c. LICENSE NUMBER
<i>D01865</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12/7/92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>GERARD CHURCH 8 GREENBACH ROAD SEVERNA PARK MD 2146</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 8 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text in the upper middle section.

Handwritten text in the middle right section.




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92 37390

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ethel Carter | | | | 2. DATE OF DEATH
MONTH 12 DAY 5 YEAR 92 | | | | 3. TIME OF DEATH
2P | | | |
| 4. SOCIAL SECURITY NUMBER
577 10 3423 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
82 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | 7. DATE OF BIRTH (Month, Day, Year)
March 12, 1910 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number)
ANNE ARUNDEL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ANNAPOLIS | | | | 9c. COUNTY OF DEATH
ANNE ARUNDEL | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION
ANNAPOLIS | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
3328 Arundel on the Bay Road | | | | | | 10f. ZIP CODE
21401 | | 10g. CITIZEN OF WHAT COUNTRY?
United states | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SUPERVISOR, RETIRED | | | | 16b. KIND OF BUSINESS/INDUSTRY
PRIVATE | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM K. LEMON | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
FLORENCE L. MARTIN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROBERT CARTER (NEPHEW) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5012 12th St., N.E. Washington, D.C. 20017 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. OLIVET CEMETERY 12/10 | | | | DATE
12/10 | | 20c. LOCATION — City or Town, State
WASHINGTON, D.C. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 M859 | | | | 22. NAME AND ADDRESS OF FACILITY
ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike, Dist Hts, Md. 20747 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Leukemia
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate interval Between Onset and Death
1 month | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | | | 29c. LICENSE NUMBER
D16354 | | 29d. DATE SIGNED (Month, Day, Year)
12/4/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
EW COLE 900 BESTGATE ANNAP MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 08 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

92 37391

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
KARL COFFMAN | | | | 2. DATE OF DEATH
MONTH 12 / DAY 23 / YEAR 1992 | | 3. TIME OF DEATH
12:48 AM | |
| 4. SOCIAL SECURITY NUMBER
218 82 8142 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
29 YRS. | | 7. DATE OF BIRTH
MONTH June / DAY 29 / YEAR 1963 | |
| 9a. FACILITY NAME (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE CITY | | 9c. COUNTY OF DEATH
BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Baltimore City | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
217 33rd Street | | | | 10f. ZIP CODE
21218 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Musician | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William R Coffman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marie Shipley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs Marie P Coffman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3501 St Paul St Balto. Md 21218 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metro Crematory | | DATE
12/26 | | 20c. LOCATION — City or Town, State
Catonsville Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Harry H. Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Harry H Witzke Funeral Home Inc.
4112 Old Columbia Pikeellicott City | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Acute Myocardial Infarction</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
AIDS | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>M.H. Ford, MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
12/23/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
Mary Nell Ford John Hopkins Hospital 600 N. Wolfe Baltimore MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 28 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

June 24, 1967

19

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Baltimore City

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92 37392

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Robert Taylor Davis</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>12-13-92</i> | | 3. TIME OF DEATH
<i>936A</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>486-12-5209</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input type="checkbox"/> F
<i>1</i> | | 6. AGE (In yrs. last birthday)
<i>73</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>04 22 1919</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Lentner, MO</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>P.G. Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Cheverly</i> | |
| 9c. COUNTY OF DEATH
<i>Prince George's</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Prince George's</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Hyattsville</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>5613 Quincy Street</i> | |
| 10f. ZIP CODE
<i>20784</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Electrical Engineer</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Defense Department</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Robert Ernest Davis</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Amanda Virginia Taylor</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Julia I. Davis</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5613 Quincy Street, Hyattsville, MD 20784</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Fort Lincoln Cemetery 11/17/92</i> | | | |
| 20c. LOCATION — City or Town, State
<i>Brentwood, MD</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack D. Friend</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
<i>Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive atherosclerotic cardiovascular disease</i>

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
a. _____
b. _____
c. _____
d. _____ | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_____ | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
<i>M</i> | | | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Angelo P. Lopez MD</i> | | | |
| 29c. LICENSE NUMBER
<i>D21230</i> | | | | 29d. DATE SIGNED (Month, Day, Year)
<i>12-13-92</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Angelo P. Lopez MD, 5009 Rayburn Ct Lp Spv. Md 20748</i> | | | | 31. DATE FILED (Month, Day, Year)
<i>DEC 16 1992</i> | | | |
| 32. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Randall</i> | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be completed by the attending physician and completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed within 24 hours after death, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37393

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Louise C DE VAUGHN | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 9, 1992 | | 3. TIME OF DEATH
12:08 AM | |
| 4. SOCIAL SECURITY NUMBER
249-14-1642 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | |
| 7a. FACILITY NAME (If not institution, give street and number)
Prince George's Hospital | | 7b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 7c. COUNTY OF DEATH
Prince George's | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Upper Marlboro | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
3118 Pyles Drive | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
11th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Legal Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
Library of Law Library/Congress | |
| 17. FATHER'S NAME (First, Middle, Last)
Alonzo E. Belch | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rosa Eva Mays | | |
| 19a. INFORMANT'S NAME (Type/Print)
Raymond E. DeVaughn | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 A-F | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington Natl. Cem | | 20c. LOCATION — City or Town, State
12 12 92 Suitland Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd Clinton, Md 20735 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Hypertensive arteriosclerotic cardiac | | | |
| | | b. vascular disease | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | 29c. LICENSE NUMBER
D12879 | | 29d. DATE SIGNED (Month, Day, Year)
Dec 10, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALFONSO VALLE MD 10701 TRAFLET DR., LARGO, MD 20772 | | | | | |
| 31. DATE FILLED (Month, Day, Year)
DEC 17 1992 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows the injury or other traumatic event, the medical examiner must be notified at once.

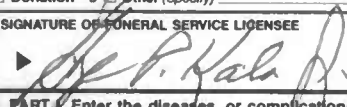
92-7157-033

blh

92 37394

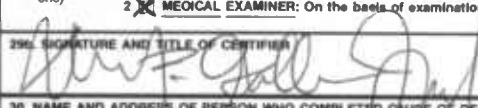
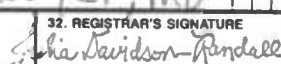
1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Adele Dunmire | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 14 1992 | | 3. TIME OF DEATH
5:50 PM | |
| 4. SOCIAL SECURITY NUMBER
219-48-4742 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
5/23/24 | |
| 8. BIRTHPLACE (State or Foreign Country)
Germany | | | | 9a. FACILITY NAME (If not institution, give street and number)
3130 Brinkley Road-Apt. 204 | | 9b. CITY, TOWN OR LOCATION OF DEATH
Temple Hills | |
| 9c. COUNTY OF DEATH
Prince Georges | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George | |
| 10c. CITY, TOWN OR LOCATION
Temple Hills | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
3130 Brinkley Rd. Apt. 204 | |
| 10f. ZIP CODE
20748 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
12th | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
at home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Gerhard E. Meier | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Aleida Agten | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Bridgette Kuehling | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RR1 Box1426 Beach Lake, Pa. 18405 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arlington National Cem. 12/18/92 Arlington, Va. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
12 15 1992 | | | |
| 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
O.C.M.E. | | | |
| 29d. DATE SIGNED (Month, Day, Year)
12 15 1992 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLIE, JR., MD 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 is marked, or item 28 is marked, the medical examiner must be notified at once.

92 37395

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
FLORENCE MAE DODGSON | | | | 2. DATE OF DEATH
MONTH 12 DAY 19 YEAR 1992 | | 3. TIME OF DEATH
5:20 P M | |
| 4. SOCIAL SECURITY NUMBER
198-22-7062 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
11 10 1908 | |
| 8. BIRTHPLACE (State or Foreign Country)
Dunmore, PA | | | | 9a. FACILITY NAME (If not institution, give street and number)
5813 Rittenhouse Street | | 9b. CITY, TOWN OR LOCATION OF DEATH
Riverdale | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Riverdale | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
5813 Rittenhouse Street | |
| 10f. ZIP CODE
20737 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) --- | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Office Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
Direct Mail Advertising | |
| 17. FATHER'S NAME (First, Middle, Last)
William Melvin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Genevieve Howell | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jeanmarie D. Kircher | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2047 Rosemont Ave., N.W., Washington, DC 20010 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 12/23/92 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute myelogenous leukemia</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<i>George S. Shashaty, M.D.</i> | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>George S. Shashaty, M.D.</i> | | | | 29c. LICENSE NUMBER
6159 (D.C.) | | 29d. DATE SIGNED (Month, Day, Year)
Dec 22, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be returned to the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37396

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Howard W. Davis | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 16, 1992 | | 3. TIME OF DEATH
M
9:40 A. | | | | |
| 4. SOCIAL SECURITY NUMBER
220-07-4137 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
March 25, 1917 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Hyattsville Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hyattsville | | | 9c. COUNTY OF DEATH
Prince George's | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Wheaton | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
12303 Barbara Road | | | | 10f. ZIP CODE
20906 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 3rd grade
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | | 16b. KIND OF BUSINESS/INDUSTRY
Self-Employed | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Unknown | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sherrie Davis (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6833-B Riverdale Rd. #201 Riverdale, Md. 20737 | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place)
Greenwood Cemetery | | DATE
12/19/92 | | 20c. LOCATION — City or Town, State
Washington, D.C. | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Janet C. Henderson</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Rollins Funeral Home, Inc.
4339 Hunt Place, N.E. Wash. D.C. 20019 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Pneumonia (Aspiration)

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Impaired Gag Reflex
Cerebrovascular Accident.
Hypertension. | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Aphasia.
Senile Dementia. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Stuart Turkett M.D.</i> | | | | 29c. LICENSE NUMBER
D310001 | | 29d. DATE SIGNED (Month, Day, Year)
12/17/92 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED DEATH (ITEM 27) (Type, Print)
Stuart Turkett, M.D. | | | | 7500 Greenway Ctr. Dr. #430
Greenbelt, Md. 20770. | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rendell</i> | | | | | | |

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92 37397

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Lillian V. Duncan</u> | | | | 2. DATE OF DEATH
MONTH <u>12</u> DAY <u>20</u> YEAR <u>92</u> | | 3. TIME OF DEATH
<u>3:30</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>214-42-2629</u> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>79</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>8-16-13</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>PENNSYLVANIA</u> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Suburban Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Bethesda</u> | | 9c. COUNTY OF DEATH
<u>Montgomery</u> | |
| 10a. STATE
<u>MD</u> | | 10b. COUNTY
<u>Montgomery</u> | | 10c. CITY, TOWN OR LOCATION
<u>Rockville</u> | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<u>1707 VEIRS MILL ROAD</u> | | | | 10f. ZIP CODE
<u>20851</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<u>WHITE</u> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
<u>12</u> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>HOMEMAKER</u> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>EDWARD W. DUNCAN (SON)</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>4602 BAYNE COURT ROCKVILLE, MARYLAND 20853</u> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>PARKLAWN CEMETERY</u> | | 20c. LOCATION — City or Town, State
<u>12/22 ROCKVILLE, MARYLAND</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>James S. Ooley</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Aspiration Pneumonitis</u> | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. <u>Chronic Obstructive Pulm Disease</u> | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Hypertension</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Phyllis Schreiner, M.D.</u> | | | | 29c. LICENSE NUMBER
<u>D26520</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>12/20/92</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>PHYLLIS SCHREINER, M.D. 50 W. EDMONSTON DRIVE #602 ROCKVILLE, MD 20852</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>DEC 22 '92</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>John Davidson-Pendell</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1009 34

22

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37398

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Gladys D. Duchon | | | | 2. DATE OF DEATH
MONTH 12 DAY 14 YEAR 92 | | 3. TIME OF DEATH
1:10 p.m. | |
| 4. SOCIAL SECURITY NUMBER
213-74-4572 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
6-11-99 | |
| 9a. FACILITY NAME (If not institution, give street and number)
NATIONAL LUTHERAN HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ROCKVILLE | | 9c. COUNTY OF DEATH
MONTGOMERY CO. | |
| 10a. STATE
MD. | | | | 10b. COUNTY
BALTIMORE CITY | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
5620- READY AVENUE | | | |
| 10f. ZIP CODE
NOT AVAILABLE | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
SEAMSTRESS | | 16b. KIND OF BUSINESS/INDUSTRY
SEWING | |
| 17. FATHER'S NAME (First, Middle, Last)
LOUIS SMEASTAD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HANNAH MARIE MARKESON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
REV.DR. REICHARD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9701- VEIRS DR., ROCKVILLE, MD. 20850 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
PARKWOOD CEMETERY 12/17 | | 20c. LOCATION — City or Town, State
BALTIMORE, MD. | | 20d. DATE
12/17 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>W. M. [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
HYSONG CO., INC.
1300- N STREET, N.W., WASH., DC | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrhythmia
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
Coronary Artery Disease | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers Disease | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D33138 | | 29d. DATE SIGNED (Month, Day, Year)
12-15-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Daniel A. Jaller, 7951 Doctors Dr Germantown, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, TO THE FUNERAL DIRECTOR: After this certificate has been properly completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37399

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROBERT C. DUNIGAN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-19-92 | | 3. TIME OF DEATH
1200 PM | |
| 4. SOCIAL SECURITY NUMBER
578-07-0164 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
OCT. 26, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country)
WASHINGTON, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
CALVERT COUNTY NURSING CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
PRINCE FREDERICK | |
| 9c. COUNTY OF DEATH
CALVERT | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
CALVERT | |
| 10c. CITY, TOWN OR LOCATION
PRINCE FREDERICK | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
2765 ADELINA ROAD | |
| 10f. ZIP CODE
20678 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
ROUTE AGENT | | | | 16b. KIND OF BUSINESS/INDUSTRY
WASHINGTON POST | | | |
| 17. FATHER'S NAME (First, Middle, Last)
ROBERT W. DUNIGAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
EVA HARDY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
KATHRYN E. GRAHAM (DAUGHTER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2765 ADELINA ROAD PRINCE FREDERICK, MARYLAND 20678 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GATE OF HEAVEN CEMETERY 12/23 | | | |
| 20c. LOCATION — City or Town, State
SILVER SPRING, MARYLAND | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Steven J. Stead</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA

Due to (or as a consequence of):
Chronic obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Due to (or as a consequence of):
Disease | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- Multiple Cerebrovascular Accident
- Sleep Apnea Syndrome | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Pranav Mathur MD</i> | | | |
| 29c. LICENSE NUMBER
D-25435 | | | | 29d. DATE SIGNED (Month, Day, Year)
12/19/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MUKESH N. MATHUR, M.D. PRINCE FREDERICK, MD 20678 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>John B. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET

SECRET

SECRET

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37400

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|-----------------------------------|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GENEVIEVE PETERS DEVANEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 22, 1992 | | 3. TIME OF DEATH
6:55 P. M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
577-58-9436 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Aug. 21, 1904 | | 8. BIRTHPLACE (State or Foreign Country)
Nebraska | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
CARRIAGE HILL-BETHESDA | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | | | 9c. COUNTY OF DEATH
MONTGOMERY | | | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Rockville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
10201 Grosvenor Place, #316 | | | | 10f. ZIP CODE
20852 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) College (1-4 or 5+)
4 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Albert Peters | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Flora Mundt | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert A. Devaney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4209 Saul Road Kensington, Maryland 20895 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 12/24/92 | | 20c. LOCATION — City or Town, State
Silver Spring, MD | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Will E. Brandy M00672 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 1357 Wisconsin Avenue, Bethesda, Maryland 20814- | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Atherosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Reflux Esophagitis, Chronic Atrial Fibrillation,
Congestive Heart Failure, Chronic Obstructive Lung Disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL:
1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one)
OTHER:
4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Irving Mizus, M.D. | | 29c. LICENSE NUMBER
D26571 | | 29d. DATE SIGNED (Month, Day, Year)
December 23, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Irving Mizus, M.D. 5413 Cedar Lane, #206C Bethesda, Maryland 20814 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

047.30

The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE REGISTER: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37401

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EUGENE G. DANDY | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 3, 1992 | | 3. TIME OF DEATH
8:05P M | |
| 4. SOCIAL SECURITY NUMBER
423-01-7710 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
MAY 13 1913 | | 8. BIRTHPLACE (State or Foreign Country)
Butler, Ga. | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Prince George's Hosp. Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
D.C. | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Washington | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
5169 Sheriff Rd., N.E. | | 10f. ZIP CODE
20019 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 9th
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Engineer | | 16b. KIND OF BUSINESS/INDUSTRY
D.C. Gov't. School System | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Dandy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary L. Srallings | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Eugene G. Dandy, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3214 Auchentoroly Terr., Balt., Md. 21217 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Mem. Park 12/8/92 | | 20c. LOCATION — City or Town, State
Landover, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Darryl H. Pratt | | 22. NAME AND ADDRESS OF FACILITY
H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Cancer of Lungs & Bones
DUE TO (OR AS A CONSEQUENCE OF):
Cancer of the prostate
DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
arteriosclerotic cardiovascular disease | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
W. M. G. M. D. | | 29c. LICENSE NUMBER
012879 | |
| 29d. DATE SIGNED (Month, Day, Year)
DEC 4 1992 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALFONSO VALLE M.D. 10704 TRAFALGAR DR, LARGO, MD 20772 | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 09 1992 | | 32. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | | |

10/10/10
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10/10/10
10/10/10

92 37402

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--------------------------------|---|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Ann Dutton | | | | 2. DATE OF DEATH
MONTH 12 DAY 03 YEAR 1992 | | | | 3. TIME OF DEATH
8:30 AM M | | |
| 4. SOCIAL SECURITY NUMBER
678-52-0003 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
54 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 27, 1938 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | |
| 9a. FACILITY NAME (If not institution, give street and number)
6106 Breezewood Dr. # 103 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Greenbelt, Md. | | | | 9c. COUNTY OF DEATH
Prince George's | | |
| 10a. STATE
Md. | | | 10b. COUNTY
Prince George's | | | 10c. CITY, TOWN OR LOCATION
Greenbelt | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6106 Breezewood Dr. # 103 | | | | 10f. ZIP CODE
20770 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (14 or 5+) --- | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | | | 16b. KIND OF BUSINESS/INDUSTRY
Dept. of Defense | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Redmond Quinn | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ann McGinnis | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Kathleen Rockinberg | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6164 Kara's Walk, Elkridge, Md. 21227 | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery | | DATE
12/7/92 | | 20c. LOCATION — City or Town, State
Washington, D.C. | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jack D. Friend | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → LIVER FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
CIRRHOSIS
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
3 mos
1 yr | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER
(Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Barry Epstein | | | | 29c. LICENSE NUMBER
D-1700 (MD) | | | | 29d. DATE SIGNED (Month, Day, Year)
12/03/1992 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Barry Epstein 6201 Greenbelt Road, #U16, College Park, Maryland 20740 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 07 1992 | | | | 32. REGISTRAR'S SIGNATURE
Jill Davidson-Randell | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



9



JACQUELINE M. ENGLISH

92 37403

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Jaqueline M. English</i> | | | | 2. DATE OF DEATH
MONTH <i>12</i> - DAY <i>18</i> - YEAR <i>92</i> | | 3. TIME OF DEATH
<i>3:10 P</i> M | |
| 4. SOCIAL SECURITY NUMBER
228 70 0702 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
44 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Aug 21, 1948 | |
| 9a. FACILITY NAME (If not institution, give street and number)
3905 Kae Court | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Ft. Washington | | 9c. COUNTY OF DEATH
Prince Georges | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Ft. Washington | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3905 Kae Court | | | | 10f. ZIP CODE
20744 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 8+) <i>College</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Clerk Cashier | | 16b. KIND OF BUSINESS/INDUSTRY
Safeway Inc. | |
| 17. FATHER'S NAME (First, Middle, Last)
ROBERT R. SPINNER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
PEARL S. DYER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROBERT ENGLISH (HUSBAND) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7200 Jaywick Ave #1008 Ft. Washington, Md 20744 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park | | DATE
12/23 | | 20c. LOCATION — City or Town, State
LANDOVER, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Alex S. Pope Jr</i> M859 | | | | 22. NAME AND ADDRESS OF FACILITY
ALEXANDER S. POPE FUNERAL HOME
2617 Pennsylvania Avenue SE DC 20020 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardiovascular disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Rogelio P. Rodriguez MD</i> | | | | 29c. LICENSE NUMBER
<i>D212 30</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12-19-92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
<i>Rogelio P. Rodriguez MD, 5009 Bayburn Ct. Sp. Md 20748</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rendell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

80458 98

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

92 37404

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOYCE IRENE EMDE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12- 17 - 1992 | | 3. TIME OF DEATH
6:30 a m | |
| 4. SOCIAL SECURITY NUMBER
315-28-5772 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
61 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JUNE 14, 1931 | |
| 9a. FACILITY NAME (If not institution, give street and number)
17106 DOWNING STREET, #203 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
GAITHERSBURG | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
GAITHERSBURG | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
17106 DOWNING STREET, #203 | | | | 10f. ZIP CODE
20878 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) College (1-4 or 5+)
2 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
MEDICAL ADMINISTRATION | | 16b. KIND OF BUSINESS/INDUSTRY
DOCTOR'S OFFICE | | | |
| 17. FATHER'S NAME (First, Middle, Last)
PAUL WELLS HALLECK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
KATHERINE KARCH | | | |
| 19a. INFORMANT'S NAME (Type/Print)
PAUL L. EMDE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
206 W. 1st STREET, CHANDLER, OK 74834 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY 12/ | | 20c. LOCATION — City or Town, State
ALEXANDRIA, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Mark L. Villalta</i> | | | | 22. NAME AND ADDRESS OF FACILITY
FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W., SIL. SP., MD 2090 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. metastatic Lung cancer
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death
3 mo |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. mediastinal metastasis 2° to #1
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 3 mo |
| | | c. tracheal obstruction 2° to #1
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 1 mo |
| | | d. esophageal obstruction 2° to #1
DUE TO (OR AS A CONSEQUENCE OF): | | | | | 1 mo |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cachexia 2° to #1, 2, 3, 4 | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Albert K. Lee MD</i> | | | | 29c. LICENSE NUMBER
D31282 | | 29d. DATE SIGNED (Month, Day, Year)
12/17/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
8218 Wisconsin Ave #605, Bethesda MD 20814 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37405

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LOLORES EVANGELISTA | | | | 2. DATE OF DEATH
MONTH 12 DAY 22 YEAR 92 | | 3. TIME OF DEATH
12:45 AM | |
| 4. SOCIAL SECURITY NUMBER
128-30-3571 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
71 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
09-14-21 | |
| 8a. FACILITY NAME (If not institution, give street and number)
JOHNS HOPKINS GERIATRIC CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
BALTO. MD. | | 8c. COUNTY OF DEATH | |
| 9a. RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
722 Chillum Road | | | | 10f. ZIP CODE
20783 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:
Dominican | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Domestic | | 16b. KIND OF BUSINESS/INDUSTRY
Private Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Gavino Jaime | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Octavia Balbuena | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Altagracia Richardson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
722 Chillum Road, Hyattsville, Md. 20783 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
El Carril Cementerio 12/26/92 | | 20c. LOCATION — City or Town, State
El Carril, Haina | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, N. W. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure Pseudomonas Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. Pneumonia Frequent Aspiration
DUE TO (OR AS A CONSEQUENCE OF):
c. Bilateral CNAs & quadriplegia
DUE TO (OR AS A CONSEQUENCE OF):
d. CAD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D38849 | | 29d. DATE SIGNED (Month, Day, Year)
12/22/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

3

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Important: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37406

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
George Fillebrown FORREST | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 18 1992 | | 3. TIME OF DEATH
2:05a^m | |
| 4. SOCIAL SECURITY NUMBER
577-42-8740 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 8, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Doctor's Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | | 9c. COUNTY OF DEATH
Prince George's | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Crofton | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1704 Reynolds Street | | | | 10f. ZIP CODE
21114 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade
College (1-4 or 5+) ----- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Administrative | | 16b. KIND OF BUSINESS/INDUSTRY
National Security Agency | |
| 17. FATHER'S NAME (First, Middle, Last)
George P. Forrest | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary S. Davenport | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Georgia Roach | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1704 Reynolds Street, Crofton, Maryland 21114 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 12/21/92 | | DATE
12/21/92 | | 20c. LOCATION — City or Town, State
Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Francis Gasch</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Aspirate Pneumonia | | | | Approximate Interval Between Onset and Death
4d | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Oropharyngeal Dysphagia | | | | Approximate Interval Between Onset and Death
1wk. | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Bipolar Disorder
Medication | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Joe G. L. MD</i> | | | | 29c. LICENSE NUMBER
D33979 | | 29d. DATE SIGNED (Month, Day, Year)
12/18/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
14300 Gallant for La. David MD 2-215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Joshua Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37407

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HAROLD FLOYD | | | | 2. DATE OF DEATH
MONTH 12 DAY 7 YEAR 92 | | 3. TIME OF DEATH
1:40 P | |
| 4. SOCIAL SECURITY NUMBER
579-68-0096 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
39 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
03 09 53 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash., D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
So. Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | |
| 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGES | |
| 10c. CITY, TOWN OR LOCATION
CLINTON | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
9306 GWYNDALE COURT | |
| 10f. ZIP CODE
20785 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) College | | | |
| 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
BUS DRIVER | | | | 17. KIND OF BUSINESS/INDUSTRY
GOVERNMENT | | | |
| 18. FATHER'S NAME (First, Middle, Last)
EUGENE FLOYD, SR. | | | | 19. MOTHER'S NAME (First, Middle, Maiden Surname)
CONSTANCE PAYNE | | | |
| 20. INFORMANT'S NAME (Type/Print)
FAITHE FLOYD | | | | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9306 Gwyndale Court Clinton, MD 20735 | | | |
| 22. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK 12-12 | | | |
| 24. LOCATION — City or Town, State
LANDOVER, MD | | | | 25. SIGNATURE OF FUNERAL SERVICE LICENSEE
Kimberly C. Buscoe | | | |
| 26. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL HOME | | | | 27. 7474 LANDOVER ROAD, LANDOVER, MD | | | |
| 28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery
Approximate Interval Between Onset and Death 1 hr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. Due to (or as a consequence of):
Prothrombotic Multiple Pulm Emboli
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Immunodeficiency State Hypertension
AP Compitococcal Meningitis | | | | | | | |
| 29. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 31. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 32. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 33. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 34. DATE OF INJURY (Month, Day, Year)
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 35. TIME OF INJURY
28f. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 36. DESCRIBE HOW INJURY OCCURRED | | | |
| 37. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 38. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 39. SIGNATURE AND TITLE OF CERTIFIER
Andrew J. [Signature] | | | | 40. LICENSE NUMBER
221945 | | | |
| 41. DATE SIGNED (Month, Day, Year)
November 8, 1992 | | | | 42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
7801 Old Bridge Ave #409 Clinton, MD 20735 | | | |
| 43. DATE FILED (Month, Day, Year)
DEC 11 1992 | | | | 44. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37408

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lillie Mae Solomon Grandy
LILLIE M. GRANDY | | | | 2. DATE OF DEATH
MONTH 12 DAY 11 YEAR 92 | | 3. TIME OF DEATH
9:40 AM | |
| 4. SOCIAL SECURITY NUMBER
302-36-1414 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs., last birthday)
91 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
9 16 1901 | |
| 8. BIRTHPLACE (State or Foreign Country)
Macon, Georgia | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON, MD | | 9c. COUNTY OF DEATH
PRINCE GEORGE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Fort Washington | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4108 Flam Street | | | | 10f. ZIP CODE
20744 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
Black | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Practical Nurse | | 16b. KIND OF BUSINESS/INDUSTRY
Private Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Solomon | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lula Solomon Solomon | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Cecil Austin Grandy (step-son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4108 Flam Street, Fort Washington, Maryland 20744 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Glenwood Cemetery 12/17/92 | | 20c. LOCATION — City or Town, State
Washington, D.C. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Carey H. Solomon | | | | 22. NAME AND ADDRESS OF FACILITY
Latney's Funeral Home
3831 Georgia Avenue, N.W., Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Prolonged Edema, acute
DUE TO (OR AS A CONSEQUENCE OF):
b. Incline Arterial disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertensive shock
DUE TO (OR AS A CONSEQUENCE OF):
d. Metabolic acidosis | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Sinus Bradycardia at autopsy | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
James P. [Signature] | | | | 29c. LICENSE NUMBER
D20824 | | 29d. DATE SIGNED (Month, Day, Year)
12/11/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John (Judson) 9450 Penn. Ave. #18 Upper Merion, Pa. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 17 1992 | | 32. REGISTRAR'S SIGNATURE
Johanna Davidson-Randall
MD 20712 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FREDDIE GREEN

DECEMBER 1, 1992

8:10PM

92 37409

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
FREDDIE GREEN | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 1, 1992 | | 3. TIME OF DEATH
8:10 P.M. | |
| 4. SOCIAL SECURITY NUMBER
255 44 4548 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
61 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
NOV 5, 1931 | | 8. BIRTHPLACE (State or Foreign Country)
Georgia | | 9. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. FACILITY NAME (If not institution, give street and number)
Prince Georges General Hospital | | 10b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | | 10c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10d. STATE
MARYLAND | | 10e. COUNTY
PRINCE GEORGES | | 10f. CITY, TOWN OR LOCATION
SEAT PLEASANT | |
| 10g. STREET AND NUMBER
511 Date Leaf Avenue | | 10h. ZIP CODE
20743 | | 10i. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
Black | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
SUPERVISOR | |
| 17. FATHER'S NAME (First, Middle, Last)
FRIENDLY GREEN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SUSIE MAE HARPER | | 19. MOTHER'S NAME (First, Middle, Maiden Surname)
SUSIE MAE HARPER | |
| 19a. INFORMANT'S NAME (Type/Print)
JEANETTE B. GREEN (wife) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
511 Dateleaf Avenue, Seat Pleasant, Md. 20743 | | 20. LOCATION — City or Town, State
LAUREL, MARYLAND | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland National cem. 12/7/92 | | 20c. LOCATION — City or Town, State
LAUREL, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Alex S. Pope Jr. | | 22. NAME AND ADDRESS OF FACILITY
ALEXANDER S. POPE FUNERAL HOME
5538 Marlboro Pike, Dist Hts Md 20747 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Hypertensive arteriosclerosis
Cardiovascular disease
Richetta Mullins | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Hypertensive arteriosclerosis
Cardiovascular disease
Richetta Mullins | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Almonzo Wall MD | | 29c. LICENSE NUMBER
D12879 | |
| 29d. DATE SIGNED (Month, Day, Year)
Dec 2, 1992 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. F. S. VALLE, MD, 10701 TRAFLET DR, LARRO, MD 20712 | | 31. DATE FILED (Month, Day, Year)
DEC 08 1992 | |
| 32. REGISTRAR'S SIGNATURE
Gina Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 is marked, or item 28 is marked, the medical examiner must be notified at once.

00470 SE

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[Faint handwritten text or signature]

92 37410

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Douglas Harold Gossett | | | | 2. DATE OF DEATH
MONTH DEC DAY 16 YEAR 1992 | | 3. TIME OF DEATH
9:51 A M | |
| 4. SOCIAL SECURITY NUMBER
216-02-2422 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
21 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7. DATE OF BIRTH
(Month, Day, Year)
FEB 17, 1971 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | | | 9. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Prince George's Gen. Hosp. | | | | 9c. COUNTY OF DEATH
Prince George's | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Clinton | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8501 Weimar Ct. | | | | 10f. ZIP CODE
20735 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Night Manager | | 16b. KIND OF BUSINESS/INDUSTRY
Billiards Hall | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Douglas M. Gossett | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Harriett A. Barbour | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Douglas M. Gossett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 A-F | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 12 19 92 Clinton, Maryland | | DATE
12 19 92 | | 20c. LOCATION — City or Town, State
Clinton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd Clinton, Md
20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intraventricular hemorrhage | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): b. Head injury | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Fracture Left Zygomatic arch
Fracture of mandible, left | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
DEC 8 1992 | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
slipping off of but wooden fence | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Roadway | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
McKendree Rd, Broadwin | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> DEPUTY M.E. | | | | 29c. LICENSE NUMBER
D12879 | | 29d. DATE SIGNED (Month, Day, Year)
DEC 16, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ARFONSD VILLE, M.D., 10701 TROFTON DR, LARGO, MD 20772 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37411

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

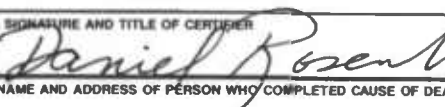

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Myrtle Yost Garner | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 17, 1992 | | 3. TIME OF DEATH
12:37 p | |
| 4. SOCIAL SECURITY NUMBER
216-40-8098 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
92 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
December 21, 1899 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
4414 Clearbrook Lane | | 9b. CITY, TOWN OR LOCATION OF DEATH
Kensington | |
| 9c. COUNTY OF DEATH
Montgomery | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Kensington | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4414 Clearbrook Lane | | | | 10f. ZIP CODE
20895 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Teacher | | 16b. KIND OF BUSINESS/INDUSTRY
Education | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Henry Yost | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Elizabeth McDonald | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sheri Lee Diegelmann-Doyle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Noblewood Court Gaithersburg, Maryland 20878 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
December 18, 1992
Montgomery Crematorium Inc. | | 20c. LOCATION — City or Town, State
Bethesda, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 M00335 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):

b. Arteriosclerotic vascular disease
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death
2 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Decubitus ulcer, inanition, abcess | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL:
1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER:
4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D04766 | | 29d. DATE SIGNED (Month, Day, Year)
December 18, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Daniel Rosenblum M.D. 10400 Connecticut Avenue Kensington, Maryland 20895 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37412

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MILDRED GOLDSTEIN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 14, 1992 | | | | 3. TIME OF DEATH
10:00 P. M. | | | | | |
| 4. SOCIAL SECURITY NUMBER
054-10-3214 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
APRIL 29, 1911 | | 8. BIRTHPLACE (State or Foreign Country)
NEW YORK | |
| 9a. FACILITY NAME (If not institution, give street and number)
263 CONGRESSIONAL LANE, #406 | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ROCKVILLE | | | | 9c. COUNTY OF DEATH
MONTGOMERY | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
ROCKVILLE | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
263 CONGRESSIONAL LANE, #406 | | | | | | 10f. ZIP CODE
20852 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
BOOKKEEPER | | | | 16b. KIND OF BUSINESS/INDUSTRY
NEW YORK CITY GOVERNMENT | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
LOUIS WINTER | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MINNIE ROSNER | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Linda Langsam | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7355 Kindler Road Columbia, MD. 21046 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. HEBRON CEMETERY | | | | DATE
12/17 | | 20c. LOCATION — City or Town, State
FLUSHING, NEW YORK | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Gary M. Gise</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Carcinoma</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Carcinoma of the oral pharynx</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>Hypertensive cardiovascular disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death
<i>HQS</i>
<i>HQS</i>
<i>HQS</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_____ | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)

_____ | | 28b. TIME OF INJURY
M _____ | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED

_____ | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

_____ | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

_____ | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Albert H. Grollman M.D.</i> | | | | | | 29c. LICENSE NUMBER
002404 | | 29d. DATE SIGNED (Month, Day, Year)
12/15/1992 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALBERT H. GROLLMAN, M.D., 1106 SPRING STREET, SILVER SPRING, MD 20910 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | | | | | | | | | |

STATE SE

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92 37413

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

92 37414

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Theresa GRIESMER</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>12 21 1992</i> | | 3. TIME OF DEATH
<i>0441 AM</i> | | |
| 4. SOCIAL SECURITY NUMBER
<i>065-09-9855</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>88</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>11-9-04</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Shady Grove Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Rockville</i> | | 9c. COUNTY OF DEATH
<i>Montgomery</i> | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Montgomery</i> | | 10c. CITY, TOWN OR LOCATION
<i>Gaithersburg</i> | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
<i>19310 Club House Road</i> | | | | 10f. ZIP CODE
<i>20879</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>white</i> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
<i>12</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>housewife</i> | | 15b. KIND OF BUSINESS/INDUSTRY
<i>own home</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Frank Hereth</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Julia Hereth</i> | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Debbie Boland</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3218 Thornapple St., Rockville, Md. 20815</i> | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Metropolitan Crematory Dec. 21, 92</i> | | 20c. LOCATION — City or Town, State
<i>Alex., Va.</i> | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Debbie Boland</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>DeVol Funeral Home
2222 Wisconsin Ave, N.W., Wash., D.C. 20007</i> | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Asystole</i> | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | |
| a. <i>Asystole</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. <i>Atherosclerotic Cardiovascular disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. <i>Hypertension</i>
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S. Abulfarag</i> | | | | 29c. LICENSE NUMBER
<i>31391 D</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12/21/92</i> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>S. Abulfarag, M.D., 19261 Montgomery Village Ave., Gaithersburg, Md.</i> | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 23 '92</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Davidson</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

P

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 1 20

x

x

9

1 - FOR
STATE
REGISTER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PATRICIA GHENT | | | | 2. DATE OF DEATH
MONTH DECEMBER DAY 16 , YEAR 1992 | | 3. TIME OF DEATH
10:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER
218-54-9811 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
35 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
FEB. 26, 1957 | | 8. BIRTHPLACE (State or Foreign Country)
WASHINGTON, DC | |
| 9a. FACILITY NAME (If not institution, give street and number)
12915 VALLEYWOOD DRIVE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRING | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| 10a. STATE
MARYLAND | | | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
SILVER SPRING | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
12915 VALLEYWOOD DRIVE | | | | 10f. ZIP CODE
20906 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
TEACHER | | 16b. KIND OF BUSINESS/INDUSTRY
NATIONAL CATHEDRAL SCHOOL | |
| 17. FATHER'S NAME (First, Middle, Last)
RUSSELL J. O'CONOR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CAROLYN KELLY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
STEVEN GHENT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12915 VALLEYWOOD DRIVE, SILVER SPRING, MD 20906 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GATE OF HEAVEN CEMETERY 12/21 | | 20c. LOCATION — City or Town, State
SILVER SPRING, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Steven D. Stenel</i> | | | | 22. NAME AND ADDRESS OF FACILITY
FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W., SIL. SP., MD 2090 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { Primary Breast Cancer

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)

27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY
M

28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO

28d. DESCRIBE HOW INJURY OCCURRED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Robert J. Boccia, MD</i>

29c. LICENSE NUMBER
D29675

29d. DATE SIGNED (Month, Day, Year)
12/17/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert J. Boccia, MD 14808 Physicians LN #212 Rockville, MD

31. DATE FILED (Month, Day, Year)
DEC 24 1992

32. REGISTRAR'S SIGNATURE
<i>Jill Davidson</i> | | | | | | | |

92 37416

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JAMES ROBERT GREENE | | | | 2. DATE OF DEATH
MONTH 12 DAY 3 YEAR 92 | | 3. TIME OF DEATH
9:30 AM | |
| 4. SOCIAL SECURITY NUMBER
214-36-2941 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
2-28-1939 | |
| 8. FACILITY NAME (If not institution, give street and number)
Leland Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Reverdale | | 9c. COUNTY OF DEATH
P.G. | |
| 10a. STATE
Md | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5700 42nd Ave., #103 | | | | 10f. ZIP CODE
20781 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
8th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Electrician | | 16b. KIND OF BUSINESS/INDUSTRY
Hawkins Electric | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Lloyd Greene | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elizabeth King | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sue Ann Worsham | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5700 42nd Avenue., Hyattsville, Md. 20781 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Funeral Ser. 12/7/92 Alexandria, Va. | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jack D. Friend | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home, 4739 Baltimore Avenue Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOPULMONARY ARREST | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): CARDIOMYOPATHY
b. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE
c. DUE TO (OR AS A CONSEQUENCE OF): ATHEROSCLEROSIS
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Chronic Obstructive Pulmonary Disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. DATE SIGNED (Month, Day, Year)
12/3/92 | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Gina M. [Signature] | | 29c. LICENSE NUMBER
D25802 | | 29d. DATE SIGNED (Month, Day, Year)
12/3/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
4700 BERwyn House Rd #104 College Park MD 20740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 7 1992 | | 32. REGISTRAR'S SIGNATURE
Gina Davidson [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE WORKING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37417

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
GLADYS J. GOINGS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 09 92 | | 3. TIME OF DEATH
1:22 AM | |
| 4. SOCIAL SECURITY NUMBER
579-07-1271 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11 29 1911 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash., D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGES | |
| 10c. CITY, TOWN OR LOCATION
DISTRICT HEIGHTS | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1211 EDENVILLE DRIVE | |
| 10f. ZIP CODE
20747 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Printing Asst. | | 16b. KIND OF BUSINESS/INDUSTRY
Government | |
| 17. FATHER'S NAME (First, Middle, Last)
Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ted Mavritte | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
908 Applewood St. Capitol Heights, MD 20743 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Suburban Crematory 12-10 | | 20c. LOCATION — City or Town, State
Silver Spring, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Kimberly C. Busch</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J.B. JENKINS FUNERAL
7474 LANDOVER ROAD LANDOVER, MD 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Septicemia</i>
Due to (or as a consequence of):
b. <i>Gangrene of the leg</i>
Due to (or as a consequence of):
c. <i>Diabetes mellitus</i>
Due to (or as a consequence of):
d. <i>Hypertension</i>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Cerebrovascular accident</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>VP Boyle Attend. Phys.</i> | | | |
| 29c. LICENSE NUMBER
079897 | | | | 29d. DATE SIGNED (Month, Day, Year)
11. 992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
V. SINGH 7209A Hanover Parkway Greenbelt Md 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 11 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7.13 - 80

92 37418

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>NADINE Nadine T. Haithcock</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>DEC 28 1992 92</i> | | | | 3. TIME OF DEATH
<i>2 A.M. M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>495 12 1148</i> | | 5. SEX
<i>1 M 2 F</i> | | 6. AGE (In yrs. last birthday)
<i>72</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>MAR. 17 1920</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Missouri</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>1212733 Haskell Lane</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Bowie</i> | | | | 9c. COUNTY OF DEATH
<i>Prince Georges</i> | |
| 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Prince Georges</i> | | 10c. CITY, TOWN OR LOCATION
<i>Bowie</i> | | | | 10d. INSIDE CITY LIMITS?
<i>YES</i> 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>12733 Haskell Lane</i> | | | | 10f. ZIP CODE
<i>20716</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
<i>No</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <i>No</i> | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Computer Analyst</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>U.S. Government</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>George W. Toalson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Trixie M. Evans</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Horace P. Haithcock</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>12733 Haskell Lane Bowie Maryland 20716</i> | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Lakemont Memorial Gardens 12/10/92 Davidsonville Md.</i> | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Robert E. Evans Pres.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. CARDIAC ARREST</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>b. ARTERIOLEFATOSIS (CARDIOVASCULAR DISEASE)</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>c.</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>d.</i> | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
<i>12/1</i> | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Deputy Medical Examiner</i> | | | | 29c. LICENSE NUMBER
<i>D01852</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12-28-92</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 14 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Registrar, Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, and item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0107 31

92 37419

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Yorguy H Hakim</i> | | | | 2. DATE OF DEATH
MONTH <i>12</i> DAY <i>14</i> YEAR <i>1992</i> | | 3. TIME OF DEATH
<i>1:30 P M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>223-80-2985</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>66</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>June 26, 1926</i> | |
| 8. FACILITY NAME (If not institution, give street and number)
<i>SOUTHERN MARYLAND HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>CLINTON</i> | | 9c. COUNTY OF DEATH
<i>PRINCE GEORGES</i> | |
| 10a. STATE
<i>Maryland</i> | | | | 10b. COUNTY
<i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION
<i>Fort Washington</i> | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<i>8802 Oak Lane</i> | | 10f. ZIP CODE
<i>20744</i> | |
| 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>White</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+) <i>5+</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Librarian</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Federal Government Library of Congress</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Hanna Hakim</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Barbara Tadros</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Arcadius H. Hakim</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>8110 Collins St. Annandale, Va. 22003</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Resurrection Cemetery 12/17/92 Clinton, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Brain death</i> | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Massive intracerebral hemorrhage</i> | | | | | | | |
| c. <i>Unknown (Hypertension vs structural lesion)</i> | | | | | | | |
| d. <i>Such as AVM, etc.)</i> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<i>To be done 12/15/92</i> | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | |
| 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Sharon L. Marseles</i> | | | | 29c. LICENSE NUMBER | | | |
| 29d. DATE SIGNED (Month, Day, Year)
<i>12/14/92</i> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Sharon L. Marseles, Southern Maryland Hospital Center</i> | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 17 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15


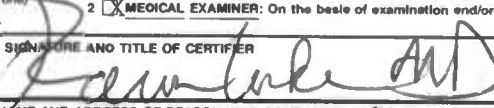
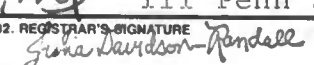
ITEMS: 23 PART I. 27 PER MEO G-695 1/21/93 reb

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37420

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
QUIANA RENEE HARDY | | | | 2. DATE OF DEATH
MONTH 12 DAY 09 YEAR 92 | | 3. TIME OF DEATH
9:25 A.M. | |
| 4. SOCIAL SECURITY NUMBER
579-96-6291 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
15 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
August 23, 1977 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
210 COLTON STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LARGO | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Upper Marlboro | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
210 Colton Street | | | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
United States of America | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) Student | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
None | |
| 17. FATHER'S NAME (First, Middle, Last)
Willie Hardy, Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Denise King | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Denise King | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
210 Colton Street, Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. LOCATION — City or Town, State
12/12/92 Landover, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 756 | | | | 22. NAME AND ADDRESS OF FACILITY
Latney's Funeral Home
3831 Georgia Ave., N.W., Washington, D.C. 2001 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. COMPLICATIONS OF INFLAMMATORY BOWEL DISEASE
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

Aaron Locke, MD | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12-09-1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 17 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37421

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Lois MARIE Hyde | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-07-92 | | 3. TIME OF DEATH
0636 A M | |
| 4. SOCIAL SECURITY NUMBER
577-24-4991 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
05-26-24 | |
| 8a. FACILITY NAME (If not institution, give street and number)
Washington Adventist Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
Takoma Park | | 8c. COUNTY OF DEATH
Montgomery | |
| 9. RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
5206 56th Avenue | | | | 10f. ZIP CODE
20781 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th Grade
College (1-4 or 6+) ----- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Payroll Accountant | | 16b. KIND OF BUSINESS/INDUSTRY
Private Industry | |
| 17. FATHER'S NAME (First, Middle, Last)
George W. Van Meter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marguerite Elizabeth Bach | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dawn M. Hyde | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 D Laurel Hill Road, Greenbelt, Maryland 20770 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
National Memorial Park 12/09/92 | | 20c. LOCATION — City or Town, State
Falls Church, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jack A. Friend | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Disease
status post Right Below Knee Amputation
Insulin Dependent Diabetes Mellitus, Renal Failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
M.D. | | 29c. LICENSE NUMBER
D22549 | | 29d. DATE SIGNED (Month, Day, Year)
12-7-92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ghulam M. Din, M.D. 6510 Kenilworth Ave., # 2600, Riverdale, Maryland 20737 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15472 SE

92 37422

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
John Anthony Higgs | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 18, 1992 | | 3. TIME OF DEATH
4:10 A. M | |
| 4. SOCIAL SECURITY NUMBER
578-22-6788 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
67 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
6-20-1925 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number)
34 Patuxent Mobile Estates | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lothian | |
| 9c. COUNTY OF DEATH
Anne Arundel | | | | 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION
Lothian | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
34 Patuxent Mobile Estates | |
| 10f. ZIP CODE
20711 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9th
College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Tile Setter | | 16b. KIND OF BUSINESS/INDUSTRY
Private Industry | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas Spencer Higgs | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Margaret Colvin | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Doris D. Higgs | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
34 Patuxent Mobile Estates Lothian, Md, 20711 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Bethel Cemetery 12-21-92 | | 20c. LOCATION — City or Town, State
Alexandria, Virginia | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | |
| 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUPERIOR VENA CAVA SYNDROME
b. LUNG CANCER
c.
d.
Approximate interval Between Onset and Death
1 MONTH
6 MONTHS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Michael York | | | | 29c. LICENSE NUMBER
D28494 | | 29d. DATE SIGNED (Month, Day, Year)
12/18/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Michael F. York, M.D. 5506 Green Landing Rd. Upper Marlboro Md. 20772 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Pandell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37423

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
EILEEN HOPSON | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-13-1992 | | 3. TIME OF DEATH
1:45pm M | |
| 4. SOCIAL SECURITY NUMBER
578-46-8957 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
83 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
1-19-1909 | | 8. BIRTHPLACE (State or Foreign Country)
London England | |
| 9a. FACILITY NAME (If not institution, give street and number)
CARRIAGE HILL BETHESDA | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
D.C. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Washington | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3133 Connecticut Avenue #425 | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Buyer | | 16b. KIND OF BUSINESS/INDUSTRY
Department Store | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Robert Hopson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Isbella McCulloch | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jean Angell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
#736
4701 Willar Avenue Chevy Chase, MD 20785 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Georgetown Med Sch. 12/13/92 Wash, D.C. | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 #846 | | | | 22. NAME AND ADDRESS OF FACILITY
Austin Royster Funeral Home
3605 14th St. N.W. Wash, D.C. 20010 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure - Uremia
DUE TO (OR AS A CONSEQUENCE OF):
b. Nephrosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
4 weeks
2 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
J. Neall Kennedy, M.D. | | | | 29c. LICENSE NUMBER
013187 | | 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IF NOT 27) (Type, Print)
Dr. J'Neall Kennedy, 1145 19th Street N.W. Washington, D.C. 20036 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 must be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CSATE 58

©

Handwritten signature

RECEIVED

92 37424

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Lillian E. Hann | | | | 2. DATE OF DEATH
MONTH 12 DAY 15 YEAR 92 | | 3. TIME OF DEATH
5:20 p m | |
| 4. SOCIAL SECURITY NUMBER
120-10-2342 | | 5. SEX
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
6-23-1908 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
NATIONAL LUTHERAN HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
ROCKVILLE | |
| 9c. COUNTY OF DEATH
MONTGOMERY CO. | | | | 10a. STATE
MD. | | 10b. COUNTY
BALTIMORE CITY | |
| 10c. CITY, TOWN OR LOCATION
BALTIMORE | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
600- LIGHT STREET | |
| 10f. ZIP CODE
21230 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CLERK | | 16b. KIND OF BUSINESS/INDUSTRY
NOT AVAILABLE | |
| 17. FATHER'S NAME (First, Middle, Last)
JESSE HANN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARGARET HARTMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
REV. DR. REICHARD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9701- VEIRS DR., ROCKVILLE, MD. | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
LOUDON PARK CEMETERY 12/18-BALTIMORE, MD. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
W.M. Hysong | | | | 22. NAME AND ADDRESS OF FACILITY
HYSONG CO., INC.
1300-N ST., NW, WASH., DC | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
{ Congestive heart failure
Atherosclerosis
RLL pneumonia
COPD
Obstructive pulmonary disease | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure
Atherosclerosis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation
3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide
5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Charles W. Karesch | | | | 29c. LICENSE NUMBER
21726 | | 29d. DATE SIGNED (Month, Day, Year)
12/16/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. KARESCH-15225-SHADY GROVE RD., ROCKVILLE, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Rodell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 is marked, or item 30 is marked, the medical examiner must be notified at once.

92 37425

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Rosel H. Hyde | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Dec. 19 1992 | | 3. TIME OF DEATH
2:30 A. M. | |
| 4. SOCIAL SECURITY NUMBER
577-60-2949 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
92 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 12 1900 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Bethesda Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION
Washington, D. C. | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2709 McKinley St. N. W. | | | | 10f. ZIP CODE
20015 | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Lawyer | | 16b. KIND OF BUSINESS/INDUSTRY
Law | | | |
| 17. FATHER'S NAME (First, Middle, Last)
George T. Hyde | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Nibley | | | |
| 19a. INFORMANT'S NAME (Type/Print)
George R. Hyde | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10007 Crestwood Road Kensington, MD 20895 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Downey Cemetery | | DATE
12/28 | | 20c. LOCATION — City or Town, State
Downey Idaho | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Henry J. Ford</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Joseph Gawler's Sons
5130 WI Ave. N.W. Washington, D.C. 20016 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Cardiopulmonary Arrest</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death
minutes | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Brachy pneumonia</i>
DUE TO (OR AS A CONSEQUENCE OF): | | | | days | |
| | | c. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Cerebrovascular Accident</i> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John P. H. [Signature]</i> | | | | 29c. LICENSE NUMBER
D33357 | | 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Lee Ina [Signature] Musher, MD 1801 E. Jefferson St. Rockville MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37426

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Wilda H. Holley | | | | 2. DATE OF DEATH
MONTH Dec. DAY 21 YEAR 1992 | | | | 3. TIME OF DEATH
7:25 A.M. | |
| 4. SOCIAL SECURITY NUMBER
578 03 8573 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Oct. 6, 1915 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number)
National Lutheran Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rockville | | | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Virginia | | | | 10b. COUNTY
Arlington | | | | 10c. CITY, TOWN OR LOCATION
none | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4421 S. 1st Street | | | | 10f. ZIP CODE
22204 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12,
College (1-4 or 5+) 2+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Home maker | | | | 16b. KIND OF BUSINESS/INDUSTRY
own home | |
| 17. FATHER'S NAME (First, Middle, Last)
Benjamin Hupt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Annie Barber | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Barbara McFadden | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1930 Albion Rd., Midlothian, Va. 23113 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
12/30/92
Solomons Lutheran Ch. | | | | 20c. LOCATION — City or Town, State
Mt. Jackson, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Thomas W. Becken</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Arlington Funeral Home
3901 N. Fairfax Dr., Arl., Va. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dementia
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. Cerebral Vascular Disease
c. Arteriosclerosis
d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>MD</i> | |
| 29c. LICENSE NUMBER
036618 | | | | | | | | 29d. DATE SIGNED (Month, Day, Year)
12-21-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
Dec 27 92 | | | | | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

3. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

4. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

92 37427

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CATHERINE DAVIS HUME | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 18 1992 | | 3. TIME OF DEATH
12:55 A M | |
| 4. SOCIAL SECURITY NUMBER
249-22-0114 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
AUG 10 1924 | | 8. BIRTHPLACE (State or Foreign Country)
SOUTH CAROLINA | |
| 9a. FACILITY NAME (If not institution, give street and number)
NATIONAL NAVAL MEDICAL CENTER | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
BETHESDA | | | | 10d. INSIDE CITY LIMITS?
1 YES 2 NO | |
| 10e. STREET AND NUMBER
6200 SINGLETON PLACE | | | | 10f. ZIP CODE
20817 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | |
| 11. MARITAL STATUS
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last)
GROVER CLEVELAND DAVIS | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
DELLA RAY | | | |
| 19a. INFORMANT'S NAME (Type/Print)
DAVID M. HUME | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6200 SINGLETON PLACE, BETHESDA MD 20817 | | | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. 12/18/92 | | | | 20c. LOCATION — City or Town, State
Bethesda, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Randy Farnal</i> M00198 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SMALL CELL LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | | | 29c. LICENSE NUMBER
007645 (MI) | | 29d. DATE SIGNED (Month, Day, Year)
12/18/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. E. DOMINGUEZ, LCDR, MC, USNR | | | | | | NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,


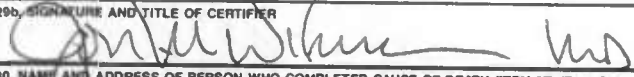
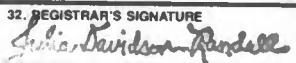
TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37428

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY B. HERSON | | 2. DATE OF DEATH
MONTH DECEMBER DAY 16 , YEAR 1992 | | 3. TIME OF DEATH
10:00 AM | |
| 4. SOCIAL SECURITY NUMBER
578-01-4312 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
NOV 25 1916 | | 8. BIRTHPLACE (State or Foreign Country)
WASHINGTON, DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
CARRIAGE HILL NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRING | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
SILVER SPRING | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
9201 SAYBROOK AVE | | 10f. ZIP CODE
20901 | |
| 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) STENOGRAPHER | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
STENOGRAPHER | | 16b. KIND OF BUSINESS/INDUSTRY
BNAI BRITH | |
| 17. FATHER'S NAME (First, Middle, Last)
ABRAHAM BISKER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ROSE SCHOOLER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JACK HERSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9201 SAYBROOK AVE. SILVER SPRING, MD. 20901 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BETH SHOLOM CEMETERY | | 20c. LOCATION — City or Town, State
12/18 CAPITOL HEIGHTS, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC
1170 ROCKVILLE PIKE, ROCKVILLE, MD. 20852 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SCLEDERMA
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | Approximate Interval Between Onset and Death
1 yr |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER
(Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | 29c. LICENSE NUMBER
12890 | | 29d. DATE SIGNED (Month, Day, Year)
16 Dec 92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JON M. WISEMAN, MD 5410 CONNECTICUT AVE. NW WASHINGTON, DC. 20016 | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.

USAF SR

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92 37429

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Miriam L Hoffman</i> | | | | 2. DATE OF DEATH
MONTH <i>13</i> DAY <i>11</i> YEAR <i>92</i> | | 3. TIME OF DEATH
<i>2040</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>577-42-1470</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>62</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>Nov. 3, 1930</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Ohio</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Washington Adventist Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Takoma Park</i> | |
| 9c. COUNTY OF DEATH
<i>Montgomery</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Prince Georges</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Cottage City</i> | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>4142 Bunker Hill Road</i> | |
| 10f. ZIP CODE
<i>20722</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: <i>white</i> | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> <i>12</i> <i>College (1-4 or 5+)</i> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Sales</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Retail Store</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Carl J. Wack</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Laura May Jones</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Carol Bailey</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>801 Natures Rd. Severna Park, MD 21146</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Cedar Hill Cemetery</i> <i>12/15/92</i> | | | |
| 20c. LOCATION — City or Town, State
<i>Suitland, MD</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Dana G. Feibach</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
<i>Marshall's Funeral Home, Inc. Suitland, MD 20746</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory failure</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. <i>Hypoxic Encephalopathy</i>
b. <i>Cardiac arrest.</i>
c. <i>Carcinoma Oesophagus.</i>
d. <i>3</i>

Approximate Interval Between Onset and Death
<i>< 1 day</i>
<i>General</i>
<i>3</i>
<i>> 3 months</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>1. Pneumonia</i>
<i>2. gastric ulceration / Perforation</i> | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
<i>M</i> | | | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Laurel Thmael</i> | | | | 29c. LICENSE NUMBER
<i>026021</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12-12-92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>4404 Queensbury Rd. #245 Riverdale, MD 20737</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 15 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Johanna Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37430

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Eleanor J. Hall</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>12-19-92</i> | | 3. TIME OF DEATH
<i>6:40 PM</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>521-24-4444</i> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>72</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>6-5-20</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>CHSS</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Silver Spring</i> | | 9c. COUNTY OF DEATH
<i>Montgomery</i> | |
| 10a. STATE
<i>MD</i> | | | | 10b. COUNTY
<i>PRINCE GEORGES</i> | | 10c. CITY, TOWN OR LOCATION
<i>HYATTSVILLE</i> | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<i>716 SOMERSET PL.</i> | | | |
| 10f. ZIP CODE
<i>20783</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>TWO</i> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>SALES CLERK</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>DRUG STORE</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>CHRISTIAN REICHENBAUGH</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>CECELIA JONES</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>HUBERT B. HALL</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>SAME AS 10e</i> | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
<i>GEORGE WASHINGTON CEM</i> | | 20c. LOCATION — City or Town, State
<i>12/23/92 ADELPHI, MD</i> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael OOB</i> | |
| 22. NAME AND ADDRESS OF FACILITY
<i>TAKOMA FUNERAL HOME</i> | | | | 22. ADDRESS OF FACILITY
<i>254 CARROLL ST NW WASHINGTON, DC</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Lung Cancer</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Jeanne P. Asher M.D.</i> | | | | 29c. LICENSE NUMBER
<i>D34032</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12/20/92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>JEANNE P. ASHER 3720 FARRAGUT AVE KENSINGTON MD 20895</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 22 '92</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rodell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

1100

1200

1300

1400

1500

1600 1700 1800 1900 2000 2100 2200 2300 2400 2500 2600 2700 2800 2900 3000 3100 3200 3300 3400 3500 3600 3700 3800 3900 4000 4100 4200 4300 4400 4500 4600 4700 4800 4900 5000 5100 5200 5300 5400 5500 5600 5700 5800 5900 6000 6100 6200 6300 6400 6500 6600 6700 6800 6900 7000 7100 7200 7300 7400 7500 7600 7700 7800 7900 8000 8100 8200 8300 8400 8500 8600 8700 8800 8900 9000 9100 9200 9300 9400 9500 9600 9700 9800 9900 10000

92 37431

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WILLIAM N. HENSE | | | | 2. DATE OF DEATH
MONTH 12 DAY 08 YEAR 92 | | 3. TIME OF DEATH
5:00 A M | |
| 4. SOCIAL SECURITY NUMBER
578-34-2687 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-18-29 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash., D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
Md. | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Forestville | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
2807 Lakehurst Avenue | |
| 10f. ZIP CODE
20747 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Korean War | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 3 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Field Engineer | | | | 16b. KIND OF BUSINESS/INDUSTRY
Vitro Corporation | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Eugene W. Hense | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marian E. Middleton | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Andrew S. Hense | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10a.-10f. | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lee Crematory 12-8-92 | | | |
| 20c. LOCATION — City or Town, State
Clinton, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Road
Clinton, Md. 20735 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septicemia.

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Recurrent Aspiration Pneumonitis.
Candidiasis
Amyotrophic Lateral Sclerosis. | | | |
| 24. Approximate Interval Between Onset and Death | | | | 25. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Gastrostomy feeding tube
Multiple Decubitus ulcers. | | | |
| 26a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 27. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 29. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 30. DATE OF INJURY (Month, Day, Year)
12/8/92 | | | |
| 31. TIME OF INJURY
M | | | | 32. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 33. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 34. DESCRIBE HOW INJURY OCCURRED | | | |
| 35. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 36. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 37. SIGNATURE AND TITLE OF CERTIFIER
Rakesh Arora, M.D. | | | | 38. LICENSE NUMBER
D20108 | | | |
| 39. DATE SIGNED (Month, Day, Year)
12/8/92 | | | | 40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Rakesh Arora, 14300 Gallant Fox Ln., #222, Bowie, Md. 20715 | | | |
| 41. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | | 42. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE DEATH CERTIFICATE OF A DECEASED PERSON MUST BE FILED WITHIN 72 HOURS AFTER DEATH. THE DEATH CERTIFICATE OF A DECEASED PERSON MUST BE FILED WITHIN 72 HOURS AFTER DEATH. THE DEATH CERTIFICATE OF A DECEASED PERSON MUST BE FILED WITHIN 72 HOURS AFTER DEATH.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



9



92 37432

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PAULINE FRANCES HARVEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 3, 1992 | | 3. TIME OF DEATH
M
9 AM | |
| 4. SOCIAL SECURITY NUMBER
579-48-6092 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
8/18/06 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Magnolia Gardens | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Md. | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Riverdale | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
5619 61st Place | |
| 10f. ZIP CODE
20737 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 yr Business | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Clerk Typist | | | | 16b. KIND OF BUSINESS/INDUSTRY
U. S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Daniel F. Reynolds | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret E. Fewkes | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Lulie H. Crump | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5619 61st Place., Riverdale, Md. 20737 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Whitfield Chapel Cemetery | | | |
| 20c. LOCATION — City or Town, State
Lanham, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jack D. Friend | | | |
| 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home 4739 Baltimore Avenue Hyattsville, Md. 20781 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial infarction

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John Davidson-Randall | | | | 29c. LICENSE NUMBER | | | |
| 29d. DATE SIGNED (Month, Day, Year)
December 3, 1992 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If M 27) (Type, Print)
John Davidson-Randall | | | |
| 31. DATE FILED (Month, Day, Year)
DECEMBER 7, 1992 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

hours after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed, it should be returned to the funeral director. The funeral director should retain this certificate for 10 years after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If the funeral director is not the one to complete the certificate, the medical examiner must be notified at once.

SEITE 28

9

92 37433

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
John Warren Hayes, Sr. | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 5, 1992 | | 3. TIME OF DEATH
10:40 A. M. | |
| 4. SOCIAL SECURITY NUMBER
578-10-2050 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
August 25, 1913 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
8028 Carey Branch Place | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fort Washington | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Fort Washington | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
8028 Carey Branch Place | |
| 10f. ZIP CODE
20744 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Police Officer | | | | 16b. KIND OF BUSINESS/INDUSTRY
D.C. Police Department | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Benson Hayes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Myrtle Jacoby | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jeanne W. Hayes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8028 Carey Branch Pl. Ft. Washington, Md. 20744 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 12/8/92 | | 20c. LOCATION — City or Town, State
Suitland, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | |
| 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
<i>Chronic renal failure</i>
<i>Withdrawal from dialysis</i>
<i>Diabetes vascular disease</i>

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes, arteriosclerosis</i> | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Thomas A. Rakowski M.D.</i> | | 29c. LICENSE NUMBER
D.C. 6051 | | 29d. DATE SIGNED (Month, Day, Year)
12/6/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THOMAS A. RAKOWSKI ARL. HOSP., ARL. VA. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 8 1992 | | 32. REGISTRAR'S SIGNATURE
<i>John W. Henderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

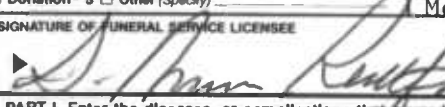
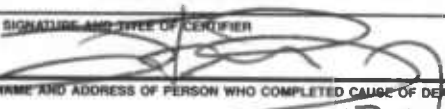
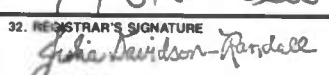
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37434

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DAVID C David Cary Jordan | | | | 2. DATE OF DEATH
MONTH 12 DAY 11 YEAR 92 | | 3. TIME OF DEATH
1430 M | |
| 4. SOCIAL SECURITY NUMBER
578-10-0516 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
11/30/1913 | |
| 8. BIRTHPLACE (State or Foreign Country)
NY, N.Y. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Takoma Park, MD | |
| 9c. COUNTY OF DEATH
MONTgomery | | | | 10a. STATE
Md | | 10b. COUNTY
Prince Georges | |
| 10c. CITY, TOWN OR LOCATION
Brentwood | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
4516 38th Street | |
| 10f. ZIP CODE
20722 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) ---- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Manager | | 16b. KIND OF BUSINESS/INDUSTRY
Pepsi-Cola | |
| 17. FATHER'S NAME (First, Middle, Last)
William F. Jordan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ethyl Merrill | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marie B. Jordan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4516 38th Street, Brentwood, Md 20722 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Crematory 12 15-92 Alexandria, Va | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, 4739 Baltimore Ave. Hyattsville, Md 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic heart disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Re-do coronary artery bypass surgery hrs
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TYPE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D40119 | | 29d. DATE SIGNED (Month, Day, Year)
12/11/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
17016 New Hampshire Ave, N.W. Washington DC 20009 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 16 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37435

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
BERNICE JOHNSON | | | | 2. DATE OF DEATH
MONTH 12 DAY 15 YEAR 1992 | | 3. TIME OF DEATH
12:37 AM | |
| 4. SOCIAL SECURITY NUMBER
438-24-7284 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9-20-1924 | |
| 9a. FACILITY NAME (If not institution, give street and number)
FORT WASHINGTON MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
FORT WASHINGTON, MD | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
MD | | | | 10b. COUNTY
TEMPLE HILLS | | 10c. CITY, TOWN OR LOCATION
TEMPLE HILLS | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
2504 DAWSON COURT | | | |
| 10f. ZIP CODE
20748 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. FATHER'S NAME (First, Middle, Last)
TOM JAMES | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY
PRIVATE | | | |
| 17. FATHER'S NAME (First, Middle, Last)
TOM JAMES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SYLVESTER KEYES | | | |
| 19a. INFORMANT'S NAME (Type/Print)
CHARLES JAMES (SON), | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2504 DAWSON CT. Hillcrest HTS MD. 20748 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK | | 20c. LOCATION — City or Town, State
Hyattsville MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James E. Williams</i> | | | | 22. NAME AND ADDRESS OF FACILITY
THE HOUSE OF WILLIAMS
3821 14th ST. N.W. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. UNCONTROLLED DIABETES MELLITUS
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. LACTIC ACIDOSIS
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
URINARY TRACT INFECTION
INFECTED DECUBITUS ULCER | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>James E. Williams</i> | | | | 29c. LICENSE NUMBER
024523 | | 29d. DATE SIGNED (Month, Day, Year)
12/16/1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
OBIORA M. OGBUAWA 1615 RHODE ISLAND AVE, N.E. WASHINGTON, D.C. 20018 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | 32. REGISTRAR'S SIGNATURE
<i>Gloria Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be used by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved.

2. The second part of the report is a detailed description of the methodology used in the study. It includes a description of the data collection methods and the statistical analysis techniques used.

3. The third part of the report is a description of the results of the study. It includes a summary of the findings and a discussion of their implications.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and the references list the sources of information used in the study.

5. The fifth part of the report is a list of appendices. These appendices contain additional information that is relevant to the study but is too large to include in the main text.

6. The sixth part of the report is a list of figures and tables. These figures and tables provide a visual representation of the data and the results of the study.

7. The seventh part of the report is a list of footnotes. These footnotes provide additional information about the study and its findings.

8. The eighth part of the report is a list of acknowledgments. These acknowledgments thank the people and organizations that have supported the study.

9. The ninth part of the report is a list of references. These references list the sources of information used in the study.

92 37436

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Donald JUNG, SR | | | | 2. DATE OF DEATH
MONTH 12 DAY 20 YEAR 92 | | 3. TIME OF DEATH
9:20 PM | |
| 4. SOCIAL SECURITY NUMBER
578-44-4884-A | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
12 04 02 | |
| 8. BIRTHPLACE (State or Foreign Country)
China | | | | 9. CITY, TOWN OR LOCATION OF DEATH
CLINTON | | 10. COUNTY OF DEATH
PRINCE GEORGES | |
| 6a. FACILITY NAME (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
N/A | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Washington, D.C. | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
4400 Chesapeake St. N.W. | | 10f. ZIP CODE
20016 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
Oriental | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (14 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Restaurant Owner | | 16b. KIND OF BUSINESS/INDUSTRY
Lee's Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last)
Hok Dong | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Yuk Yuen Tom | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William Donald Jung | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9203 Carendon Ct. Upper Marlboro, Md 20772 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington National Cem. | | 20c. LOCATION — City or Town, State
12/23/92 Suitland Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Severe metabolic acidosis
DUE TO (OR AS A CONSEQUENCE OF):
b. hypervolemia
DUE TO (OR AS A CONSEQUENCE OF):
c. acute renal failure
DUE TO (OR AS A CONSEQUENCE OF):
d. hypertension | | | | | | | |
| Approximate interval Between Onset and Death
8 hours
1 day
1 day
years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
severe peripheral vascular disease
diabetes mellitus | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D43752 | | 29d. DATE SIGNED (Month, Day, Year)
December 21, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
M. Nakamura, 7501 SURRATTS ROAD, CLINTON MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-inquest permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37437

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Willie J. JACKSON, Jr. | | | | 2. DATE OF DEATH
MONTH 12 DAY 3 YEAR 92 | | 3. TIME OF DEATH
2300 P M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
73 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 12, 1919 | | 8. BIRTHPLACE (State or Foreign Country)
Alabama | |
| 9a. FACILITY NAME (If not institution, give street and number)
Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Virginia | | 10b. COUNTY
Fairfax | | 10c. CITY, TOWN OR LOCATION
Alexandria | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2304 Beacon Hill Road | | | | 10f. ZIP CODE
22306 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (14 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Foreman | | 16b. KIND OF BUSINESS/INDUSTRY
Scrap Yard | |
| 17. FATHER'S NAME (First, Middle, Last)
Willie J. Jackson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ETA Dodds | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Lillie Mae Jackson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAME as 10 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mount Comfort Cemetery | | DATE
12/8 | | 20c. LOCATION — City or Town, State
Fairfax CO., Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Michael E. Brant | | | | 22. NAME AND ADDRESS OF FACILITY
GREENE FUNERAL HOME, INC.
814 FRANKLIN STREET
ALEXANDRIA, VIRGINIA | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intra Cerebral Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. _____
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_____ | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
D37891 | | 29d. DATE SIGNED (Month, Day, Year)
12/4/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
A RASVAN 571 MD 10313 Georgia Av #302 Silver Spring MD 20902 | | | | | | | |
| 31. DATE FILLED (Month, Day, Year)
DEC 7 1992 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET
NOFORN
NOFORN

92 37438

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELMER THOROLF KNUDSEN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 5 1992 | | 3. TIME OF DEATH
7:20PM | |
| 4. SOCIAL SECURITY NUMBER
113-22-0871 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10-12-22 | |
| 8. BIRTHPLACE (State or Foreign Country)
New York | | | | 9a. FACILITY NAME (If not institution, give street and number)
MALCOLM GROW USAF MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
ANDREWS AFB MD 20331-5300 | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
Md. | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Upper Marlboro | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
10819 Phillips Drive | |
| 10f. ZIP CODE
20772 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 4 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Intelligence Analyst U.S. Gov't | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Valdimar Thorolf Knudsen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ingrid Jacobson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Shirley L. Knudsen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10a.-10f. | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Md. State Veterans Cemetery Cheltenham, Md. 12-9-92 | | | |
| 20c. LOCATION — City or Town, State | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | |
| 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc.
6633 Old Alexander Ferry Road
Clinton, Md. 20735 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTI ORGANIC SYSTEM FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
c. ASPIRATION PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | |
| 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year)
DECEMBER, 5, 1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOHN L. HAWS, CAPT. USAF, MC
ANDREWS AFB MD 20331-5300 | | | | 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | |
| 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shall be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


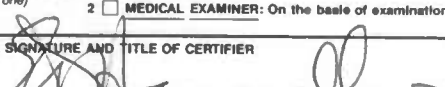
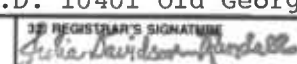
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 17 59

92 37439

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Stanley W. Kadow | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 19, 1992 | | 3. TIME OF DEATH
11:45 AM | |
| 4. SOCIAL SECURITY NUMBER
217 44 0628 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
88 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 1, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wisconsin | | 9a. FACILITY NAME (If not institution, give street and number)
Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Chevy Chase | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3307 W. Coquelin Terrace | | | | 10f. ZIP CODE
20815-4828 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) —
College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Economist | | 16b. KIND OF BUSINESS/INDUSTRY
Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Wenzel Kadow | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Petrick | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Helena C. Kadow | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20815-4828
3307 W. Coquelin Terrace, Chevy Chase, Maryland | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 12-22-92 | | 20c. LOCATION — City or Town, State
Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 M00689 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Respiratory Failure</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Congestive Heart Failure</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Pneumonia, Extracranial fistula</u>
<u>Chronic Brain Syndrome</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D21898 | | 29d. DATE SIGNED (Month, Day, Year)
12/20/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ernest Hanowell, M.D. 10401 Old Georgetown Road, Bethesda, Maryland 20814 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37440

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Vladimir P. Korolevich | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 21, 1992 | | | | 3. TIME OF DEATH
8:02 P M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
128-32-4573 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
March 14, 1913 | | 8. BIRTHPLACE (State or Foreign Country)
Russia | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Shady Grove Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rockville | | | | 9c. COUNTY OF DEATH
Montgomery | | | | | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Rockville | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
8151 Needwood Road | | | | 10f. ZIP CODE
20855 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (8-12) College (1-4 or 5+)
— 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Civil Engineer | | | | 16b. KIND OF BUSINESS/INDUSTRY
Construction | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Basilio Korolevich | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Olga Von Pelikan | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ivan V. Korolevich | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7309 Needwood Road, Rockville, Maryland 20855 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 12/24/92 | | | | 20c. LOCATION — City or Town, State
Silver Spring, Maryland | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michelle D. Kutta</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave., Rockville, Maryland 20850-2805 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. EMPHYSEMA
DUE TO (OR AS A CONSEQUENCE OF):
b. ATHEROSCLEROTIC CARDIO VASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Rudolph MD</i> | | 29c. LICENSE NUMBER
D 19268 | | 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
11420 ROCKVILLE PIKE #20, ROCKVILLE, MD 20852 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>Johanna Davidson-Rodell</i> | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The death certificate has been signed by the attending physician and completely filled in by the funeral director; page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37441

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EUGENE KAIN | | | | 2. DATE OF DEATH
MONTH 12 DAY 27 YEAR 92 | | | | 3. TIME OF DEATH
5:40 A M | | |
| 4. SOCIAL SECURITY NUMBER
127 26 5799 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
59 YRS. | IF UNDER 1 YEAR
MONTHS 01 DAYS 4 | IF UNDER 24 HRS.
HOURS 33 MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
01-4-33 | | 8. BIRTHPLACE (State or Foreign Country)
New York | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Howard County General | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Columbia | | | 9c. COUNTY OF DEATH
Howard | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Howard | | 10c. CITY, TOWN OR LOCATION
Columbia | | | 10d. INSIDE CITY LIMITS
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
10718 Hunting Lane | | | | 10f. ZIP CODE
21044 | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Dep't of Defence | | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Michael Kane | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nora Kane | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs Jean V Kain | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10718 Hunting Lane Columbia Md 21044 | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St Louis Cemetery | | | DATE
12/29 | | 20c. LOCATION — City or Town, State
Clarksville Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Harry H. Witzke | | | | 22. NAME AND ADDRESS OF FACILITY
Harry H Witzke Funeral Home Inc.
4112 Old Columbia Pike Ellicott City | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Asystole
DUE TO (OR AS A CONSEQUENCE OF):
Ventricular fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
Massive Acute Anterior Myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
Coronary artery disease
Approximate Interval Between Onset and Death
approx 1 1/2 hours
approx 1-3 hours
approx 5 hours
probably years | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER
(Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Stephen A. Valentini | | | | 29c. LICENSE NUMBER
D22681 | | | 29d. DATE SIGNED (Month, Day, Year)
12-27-92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Stephen A. Valentini | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 28 '92 | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randell | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

P

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37441

107 to 2100

Howard
10710 Hunting Lane

Columbia
21044

Michael Kane

Mrs Jean V Kane

Dep't of Justice

John Kane

10718 Hunting Lane Columbia MO 21044

St Louis Cemetery

12/29 Clarksville Maryland

Harry H. Wicks Funeral Home Inc.
4113 Old Columbia Pike Ellicott City

9

92 37442

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Peter Lally | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Dec. 8 1992 | | 3. TIME OF DEATH
2:30 PM | |
| 4. SOCIAL SECURITY NUMBER
382 26 6078 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 29 1929 | |
| 8. BIRTHPLACE (State or Foreign Country)
Michigan | | | | 9a. FACILITY NAME (If not institution, give street and number)
Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Annapolis | |
| 9c. COUNTY OF DEATH
Anne Arundel | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Crofton | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1750 Dryden Way | | | | 10f. ZIP CODE
21114 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Ticket Manager | | 16b. KIND OF BUSINESS/INDUSTRY
Washington Redskins | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank Lally | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maude (Maiden Name Unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Douglas Lally | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1680 Carlyle Drive Crofton Maryland 21114 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery 12/11/92 | | 20c. LOCATION — City or Town, State
Cheltenham Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert E. Evans, Pres. | | | | 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
8 mos |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Stuart E. Selonich, MD | | | | 29c. LICENSE NUMBER
019838 | | 29d. DATE SIGNED (Month, Day, Year)
12/9/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Stuart E. Selonich 900 Bestgate Annapolis, Md. 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 14 1992 | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 21145

1014

92 37443

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELSIE ANN LONG | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 10, 1992 | | 3. TIME OF DEATH
10:30 p m | |
| 4. SOCIAL SECURITY NUMBER
180-20-1493 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 11, 1925 | |
| 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number)
Doctors Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Lanham | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
9018 Third Street | |
| 10f. ZIP CODE
20706 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Harry Troup | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Herbert Lewis Long | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9018 Third Street, Lanham, Maryland 20706 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Vets Cemetery 12-14-92 | | 20c. LOCATION — City or Town, State
Cheltenham, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | |
| 22. NAME AND ADDRESS OF FACILITY
Rendon/Hale Lanham Funeral Home
9013 Annapolis Rd., Lanham, Maryland 20706 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. ACUTE CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
b. PULMONARY EMBOLISM
DUE TO (OR AS A CONSEQUENCE OF):
c. DEEP VENOUS THROMBOSIS
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death
20 MINUTES
LESS THAN 1 HOUR
10 DAYS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COLORECTAL CANCER, STAPHYLOCOCCAL URINARY TRACT INFECTION | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D31345 | | 29d. DATE SIGNED (Month, Day, Year)
12-12-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 14 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This law requires that the death certificate be completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked as item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37444

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY VIRGINIA LYNN
MARY LYNN | | | | 2. DATE OF DEATH
MONTH DECEMBER DAY 21 YEAR 92 | | 3. TIME OF DEATH
7:55 AM | |
| 4. SOCIAL SECURITY NUMBER
213-38-2104 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year) 09 08 1913 | |
| 8. BIRTHPLACE (State or Foreign Country)
McDowell, VA | | | | 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE'S | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Lanham | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
7219 Kempton Road | |
| 10f. ZIP CODE
20706 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Teacher | |
| 16b. KIND OF BUSINESS/INDUSTRY
P.G. County School System | | 17. FATHER'S NAME (First, Middle, Last)
Harry L. Bradshaw | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Camilla Brown Gillaspie | | 19a. INFORMANT'S NAME (Type/Print)
Bill Lynn | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
708 Carteret Street, Beaufort, SC 29902 | | 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Funeral Serv. 12/22/92 Alexandria, VA | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack D. Green</i> | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardiovascular failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { hypertension
metastatic myeloma

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
diabetes
hypertension
chronic kidney disease | | Approximate Interval Between Onset and Death | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John Davidson-Randall</i> | | 29c. LICENSE NUMBER
201699 | | 29d. DATE SIGNED (Month, Day, Year)
12/22/92 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 and 7 must be signed by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

92 37445

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Ellen Lesko | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 22, 1992 | | 3. TIME OF DEATH
6:30 A M | |
| 4. SOCIAL SECURITY NUMBER
215-54-5853 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
42 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 22, 1950 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
9803 Parr Court | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fort Washington | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Fort Washington | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
9803 Parr Court | |
| 10f. ZIP CODE
20744 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Employee Relations Mgr. | | 16b. KIND OF BUSINESS/INDUSTRY
Computer Company | |
| 17. FATHER'S NAME (First, Middle, Last)
Harry Rhatigan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Beatrice Sommers | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Teresa E. Andrews | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9803 Parr Court, Fort Washington, Md. 20744 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Cedar Hill Cemetery 12/24/92 | | 20c. LOCATION — City or Town, State
Clinton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Carcinoma of the TONGUE</u>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.
c.
d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Frank M. Ryan</i> | | | | 29c. LICENSE NUMBER
D19431 | | 29d. DATE SIGNED (Month, Day, Year)
Dec. 22, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Frank M. Ryan M.D. 6188 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Johi Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

97. 50

92 37446

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MADELINE Notter Lutz | | | | 2. DATE OF DEATH
MONTH 12 DAY 17 YEAR 92 | | 3. TIME OF DEATH
7:20 | |
| 4. SOCIAL SECURITY NUMBER
577-01-9699 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
November 2, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington DC | | | | 9. FACILITY NAME (If not institution, give street and number)
Southern Maryland Hospital | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH
Clinton, md | | | | 11. COUNTY OF DEATH
PRINCE GEORGE | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Fort Washington | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
9116 Belleau Trail | | | | 10f. ZIP CODE
20744 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
David R. Notter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Luise Schlunegger | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Louis B. Hammett, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6007 Kirby Road Clinton, Maryland 20735 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 12/19/92 | | 20c. LOCATION — City or Town, State
Suitland, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Joseph B. S. S.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home., Inc.
6633 Old Alexander Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dissected Atherosclerosis Approximate Interval Between Onset and Death
3 mos | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David N. Robb MD</i> | | | | 29c. LICENSE NUMBER
D-15847 | | 29d. DATE SIGNED (Month, Day, Year)
12-17-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DAVID N. ROBB MD 8200 Professional Pl Landover Md 20785 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND AND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

92 37447

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Kim D. Lewis | | | | 2. DATE OF DEATH
MONTH 12 DAY 17 YEAR 92 | | 3. TIME OF DEATH
7:04 A.M. | |
| 4. SOCIAL SECURITY NUMBER
108-58-5033 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
27 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
May 11, 1965 | |
| 8. BIRTHPLACE (State or Foreign Country)
New York | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Greater Laurel Beltsville Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Laurel | | 9c. COUNTY OF DEATH
Prince George | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George | | 10c. CITY, TOWN OR LOCATION
Fort Washington | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
12508 Proxmire Drive, | | | | 10f. ZIP CODE
20744 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6 Yrs | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Civil Engineer | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Chauncey Ford | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ethel Armstrong | | | |
| 19a. INFORMANT'S NAME (Type/Print) (Husband)
Mr Aaron J. Lewis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744
12508 Proxmire Dr, Ft Washington, Md | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)
Gate Of Heaven Cem. 12/22 | | 20c. LOCATION — City or Town, State
Silver Spring, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George R. Snowden</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Snowden Funeral Home P.A. 20850
246 N. Washington St, Rockville, Md | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest
CHRONIC DISEASE
DUE TO (OR AS A CONSEQUENCE OF): Acute Leukemia
Acute Leukemia
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Mula Mula</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
12-17-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Neil A. Meade Muirbirk Rd., Laurel | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

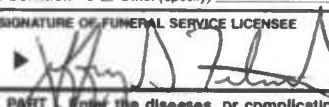
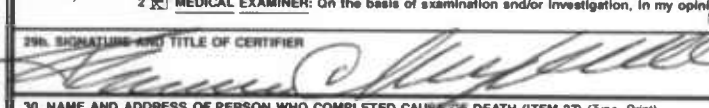

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The hospital or attending physician must sign this certificate within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37448

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Debra A. LUNDGREN | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 21 92 | | 3. TIME OF DEATH
0120A | |
| 4. SOCIAL SECURITY NUMBER
067-58-8992 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
21 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
05-08-71 | |
| 8. BIRTHPLACE (State or Foreign Country)
New York | | | | 9a. FACILITY NAME (If not institution, give street and number)
SUBURBAN HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | |
| 9c. COUNTY OF DEATH
MONTGOMERY | | | | 10a. STATE
MD | | 10b. COUNTY
MONTGOMERY | |
| 10c. CITY, TOWN OR LOCATION
GAITHERSBURG | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
1364 CARLSBAD DR | |
| 10f. ZIP CODE
20879 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) — College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
College | |
| 17. FATHER'S NAME (First, Middle, Last)
Paul E. Lundgren | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Karin F. Koerner | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Paul E. Lundgren | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1364 Carlsbad Drive, Gaithersburg, Maryland 20879 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 12-23-92 | | 20c. LOCATION — City or Town, State
Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 M00689 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE TRAUMA
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BAC = .26 | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
12 20 92 | | 28b. TIME OF INJURY
2155 | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED
MVA HIT TREE | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
5200 MONCASTER MILK RD | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D07094 | | 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FRANCIS C MYLES 1024 FERNWOOD RD BETHESDA MD 20817 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

341.

10

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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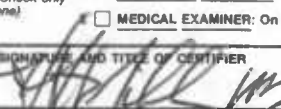
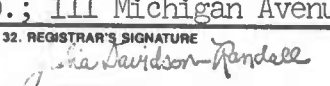


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37449

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
James Brian Little | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 5, 1992 | | 3. TIME OF DEATH
1:10 P M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER
216-19-6595 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
4 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec. 16, 1987 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
6007 Goodfellow Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Suitland | | | | 9c. COUNTY OF DEATH
Prince Georges | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Suitland | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
6007 Goodfellow Drive | | | | 10f. ZIP CODE
20746 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0
College (1-4 or 5+) none | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
none | | 16b. KIND OF BUSINESS/INDUSTRY
none | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
James A. Little | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Brenda Hamm | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
James A. Little | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6007 Goodfellow Dr., Suitland, MD 20746 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington National Cemetery 12/10/92 Suitland, MD | | 20c. LOCATION — City or Town, State
MD | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
4308 Suitland Rd.
Marshall's Funeral Home, Inc. Suitland, MD 20746 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brainstem Glioma
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 Attending Physician | | 29c. LICENSE NUMBER
D43388 | | 29d. DATE SIGNED (Month, Day, Year)
12/7/92 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Stacy Nicholson, M.D.; 111 Michigan Avenue, NW; Washington, DC 20010 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 09 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | | | |

CA/PA SE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37450

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RACHEL BELLE BILLINGSLEY LATIMER | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26 92 | | 3. TIME OF DEATH
12:42p M | | | | | |
| 4. SOCIAL SECURITY NUMBER
217-42-4142 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
82 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
9-8-1910 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PHYSICIANS MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LA PLATA | | | | 9c. COUNTY OF DEATH
CHARLES | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Charles | | 10c. CITY, TOWN OR LOCATION
White Plains | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
Rt. 1, Box 41 Billingsley Road | | | | 10f. ZIP CODE
20695 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12
College (1-4 or 5+) — | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Housewife | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Brisco Billingsley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Carrie Belle Lusby | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Nelson Guy Latimer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1, Box 41, Billingsley Rd., White Plains, Md. 20695 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Trinity Memorial Gardens | | 20c. LOCATION — City or Town, State
Waldorf, Md. | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Benjamin Matthews</i>
Benjamin Matthews MO0658 | | | | 22. NAME AND ADDRESS OF FACILITY
Huntt Funeral Home
P. O. box 156, Waldorf, Md. 20604-0156 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Cardio Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Pulmonary Embolus
DUE TO (OR AS A CONSEQUENCE OF):
Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
Diabetes Mellitus
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's disease, Hypertension | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S. Mishra</i> | | 29c. LICENSE NUMBER
D-23021 | | 29d. DATE SIGNED (Month, Day, Year)
12/26/92 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SANJEEB K. MISHRA M.D. 7C POST OFFICE ROAD WALDORF MARYLAND 20602 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 29 92 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | | | |

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF CHEMISTRY
JAN 10 1964

TO THE DIRECTOR
OF THE UNIVERSITY OF CHICAGO

FROM THE DEPARTMENT OF CHEMISTRY

RE: [Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is filled in by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 allows any injury, or other traumatic event, the medical examiner must be notified at once.

12/07/92 103
2132 BRADCH
BSV 1/P 38
619 NICHOLSON ST
WASHINGTON
FOR
STATE
201 - REGISTRAR 2766

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37451

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|-------------------------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Jessie McCormick | | | | 2. DATE OF DEATH
MONTH 12 DAY 12 YEAR 92 | | | | 3. TIME OF DEATH
0750 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER
578-38-7164 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
5-30-12 | | 8. BIRTHPLACE (State or Foreign Country)
ST. GEORGE, S.C. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
HOLYCROSS Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRING, MD | | | | 9c. COUNTY OF DEATH
MONTGOMERY | | | | | |
| 10a. STATE
D. C. | | 10b. COUNTY
WASHINGTON | | 10c. CITY, TOWN OR LOCATION
WASHINGTON | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
619 NICHOLSON ST., N. E. | | | | 10f. ZIP CODE
20011 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
BLACK | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
8TH GRADE | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
HOUSE KEEPING | | 16b. KIND OF BUSINESS/INDUSTRY
U. S. STATE DEPT. | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
ALBERT JOHNSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SUZANNE GLOVER | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ROBERT Heyward | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1853 DUTCH VILLAGE DR. LANDOVER, MD 20785 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
SHADY GROVE UNITED METH CH 12/18 ST. GEORGE, S. C. | | 20c. LOCATION — City or Town, State | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Theodore C. Pinckney | | | | 22. NAME AND ADDRESS OF FACILITY
PINCKNEY-SPANGLER FUNERAL HOME
524 - 8TH ST., N. E. | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic Chorioncarcinoma of the Rectum

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congestive Heart Failure
c. Diabetes Mellitus
d. Myocardial Infarction | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Diabetes Mellitus
Myocardial Infarction | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28. PLACE OF DEATH (Check only one)
<input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
<input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Charles H. Rose | | 29c. LICENSE NUMBER
14646 | | 29d. DATE SIGNED (Month, Day, Year)
12/13/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARTIN S. ROSE, 10810 CONNECTICUT AVE, KENNESAW, MD, 20895 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
12-16-92 | | | | 32. REGISTRAR'S SIGNATURE
Jane [Signature] | | | | | | | | | |

92 37452

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Justine L. MEADER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC. 11, 1992 | | 3. TIME OF DEATH
H M
10:05 P | |
| 4. SOCIAL SECURITY NUMBER
415-03-2940 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 12, 1905 | |
| 8a. FACILITY NAME (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
LANHAM | | 8c. COUNTY OF DEATH
PRINCE GEORGE'S | |
| 9a. RESIDENCE OF DECEDENT
10a. STATE
Maryland | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Oxon Hill | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
6618 Dulin Drive | | 10f. ZIP CODE
20745 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
5+ | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Actuary | | | | 16b. KIND OF BUSINESS/INDUSTRY
Federal Government | | 17. FATHER'S NAME (First, Middle, Last)
John T. Spradling | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Carrie Marie Winans | | | | 19a. INFORMANT'S NAME (Type/Print)
Frederick I. Meader | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6618 Dulin Drive, Oxon Hill, Maryland 20745 | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 12/15/92 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
severe hyperpyrexia probably of central origin, post-thalamic bleed, ventricular tachycardia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Schuster</i> | | | | 29c. LICENSE NUMBER
022780 | | 29d. DATE SIGNED (Month, Day, Year)
12/12/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Schuster MD 7500 Greenway Dr Dr. Greenbelt Md 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 17 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Edna Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

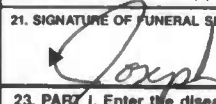
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


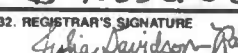
IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

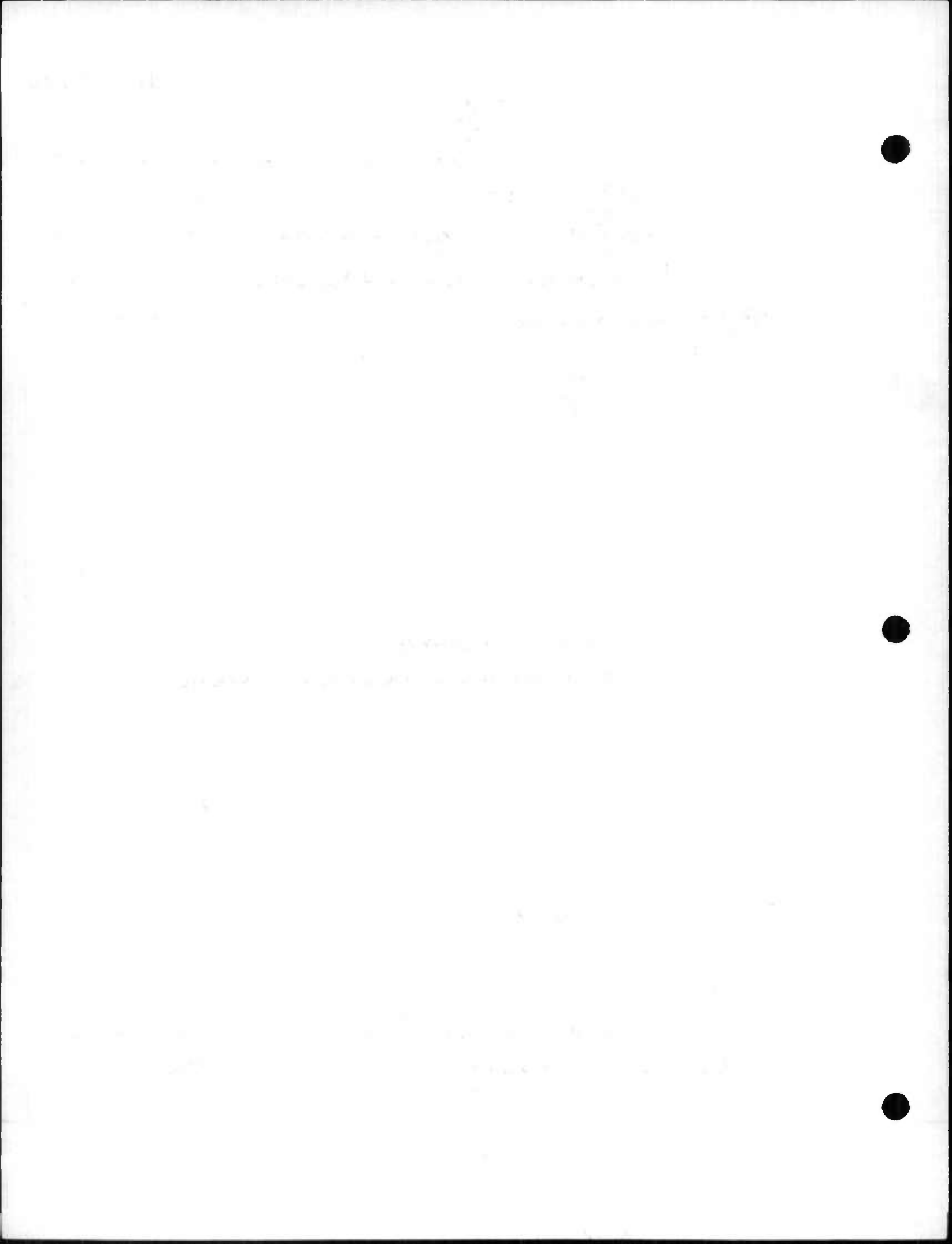
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|--|---|--|--|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Albert Maxfield | | | | 2. DATE OF DEATH
MONTH 12 DAY 14 YEAR 92 | | | | 3. TIME OF DEATH
2 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER
579-16-9909 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
84 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | 7. DATE OF BIRTH
(Month, Day, Year)
5-01-08 | | 8. BIRTHPLACE (State or Foreign Country)
Virginia | | |
| 9a. FACILITY NAME (If not institution, give street and number)
6456 Fairborn Terr. | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
NEW CARROLLTON | | | | | 9c. COUNTY OF DEATH
PRINCE GEORGES | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
PRINCE GEORGES | | | 10c. CITY, TOWN OR LOCATION
NEW CARROLLTON | | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
6456 FAIRBORN TERRACE | | | | | 10f. ZIP CODE
20784 | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Caucasian | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Painter & Cab Owner | | | | 16b. KIND OF BUSINESS/INDUSTRY
Self-Employed | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Orvis Minor Maxfield | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Unobtainable | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Donna Marie Potts | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 A-F | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 12-17-92 | | | | 20c. LOCATION — City or Town, State
Clinton, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd Clinton, Md
20735 | | | | | | | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST
DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIOVASCULAR CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_____ | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year)
N/A | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER
(Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

Deputy Medical Examiner | | | | | | 29c. LICENSE NUMBER
201852 | | | 29d. DATE SIGNED (Month, Day, Year)
12-14-92 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Paul A. DeVore, MD 4403 Greenburg Rd Hyattsville MD 20781 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 17 1992 | | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | | | |



92 37454

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Ada L. Mahoney</u> | | | | 2. DATE OF DEATH
MONTH <u>12</u> DAY <u>6</u> YEAR <u>92</u> | | 3. TIME OF DEATH
<u>5:40 AM</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>139-20-7842</u> | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>90</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>7-15-02</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Wash., D.C.</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>Regency Nursing Home</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Forestville</u> | |
| 9c. COUNTY OF DEATH
<u>Prince George's</u> | | | | 10a. STATE
<u>Md.</u> | | | |
| 10b. COUNTY
<u>Prince George's</u> | | | | 10c. CITY, TOWN OR LOCATION
<u>Forestville</u> | | | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<u>7420 Marlboro Pike</u> | | | |
| 10f. ZIP CODE
<u>20747</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u>
College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Secretary</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Federal Gov't</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>William Cooper</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Ella Penman</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Jeanette L. Davis</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6939 Halleck St., District Heights, Md.</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Ft. Lincoln Cemetery</u> | | 20c. LOCATION — City or Town, State, Zip Code
<u>Brentwood, Md. 20747</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Lee Funeral Home, Inc.
6633 Old Alexander Ferry Road
Clinton, Md. 20735</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Fatal Arrhythmia</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. <u>Conduction Disturbance</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. <u>Ischemic Heart Disease</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. <u>Coronary Artery Disease</u>
DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>None other than advanced age</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
<u>DNA</u> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <u></u> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>Richard A. Furson, MD</u> | | 29c. LICENSE NUMBER
<u>D02237 Md.</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>12-6-92</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>Richard A. Furson, MD, 12825 Old Fort Rd. Ft. Wash., Md 20744</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>DEC 10 1992</u> | | 32. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 must be attached by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report discusses the general situation of the country and the progress of the work during the year. It also mentions the results of the various investigations and the conclusions reached.

2. The second part of the report deals with the specific details of the work, including the methods used, the results obtained, and the conclusions drawn. It also mentions the various difficulties encountered and the ways in which they were overcome.

3. The third part of the report discusses the future work and the plans for the coming year. It also mentions the various resources available and the ways in which they will be used.

1. The first part of the report discusses the general situation of the country and the progress of the work during the year. It also mentions the results of the various investigations and the conclusions reached.

2. The second part of the report deals with the specific details of the work, including the methods used, the results obtained, and the conclusions drawn. It also mentions the various difficulties encountered and the ways in which they were overcome.

3. The third part of the report discusses the future work and the plans for the coming year. It also mentions the various resources available and the ways in which they will be used.

92 37455

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANNA M. MENTON | | | | | | 2. DATE OF DEATH
MONTH 12 DAY 7 YEAR 92 | | 3. TIME OF DEATH
2:17 P | |
| 4. SOCIAL SECURITY NUMBER
061-09-8527 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
83 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 4, 1909 | | 8. BIRTHPLACE (State or Foreign Country)
New York | |
| 9a. FACILITY NAME (If not institution, give street and number)
So. Maryland Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Forestville | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
2110 Brooks Drive # 302 | | | | 10f. ZIP CODE
20747 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Joseph Brienz | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Martin Menton, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8517 Madison St., New Carrollton, Maryland 20784 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 12/10/92 | | 20c. LOCATION — City or Town, State
Clinton, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jeff Macin</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Rendon/Hale Lanham Funeral Home
9013 Annapolis Rd., Lanham, Maryland 20706 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):

b. lung carcinoma
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
coronary artery disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Arthur Tmo</i> | | | | | | 29c. LICENSE NUMBER
D38388 | | 29d. DATE SIGNED (Month, Day, Year)
12.8.92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SUNIL NATHANAINI 8926 Woodyard RD CLINTON MD 20735 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John T. Anderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

92-7236-033

blh

92-242

92 37456

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Inocencia | | | | AKA - INCONSENSA BARRERA Mendez-Barrios | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 19 92 | | 3. TIME OF DEATH
4:24 p.m. | | | |
| 4. SOCIAL SECURITY NUMBER
None | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
26 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
July 20, 1966 | | 8. BIRTHPLACE (State or Foreign Country)
Canilla, Guatemala | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Wooded area | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | | | 9c. COUNTY OF DEATH
Prince Georges | | | |
| 10a. STATE
Md. | | | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville, | | | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 10e. STREET AND NUMBER
2707 Kirkwood Place # 102 | | 10f. ZIP CODE
20782 | | 10g. CITIZEN OF WHAT COUNTRY?
Guatemala | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Guatemala | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
4 Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Meat Packer | | | | 16b. KIND OF BUSINESS/INDUSTRY
Food Industry | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Luis Mendez | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Juana Barrios | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Edgar Amilcar Barrios | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2707 Kirkwood Place # 002, Hyattsville, Md. 20782 | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cementerio De Canilla 12/30/92 | | | | 20c. LOCATION — City or Town, State
San Juan Guatemala | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Christine Gasch</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home - 4739 Baltimore Ave., Hyattsville, Md. 20781 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wounds of Head
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) wooded area | | | | | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY
(Month, Day, Year)
Found 12/19/92 | | 28b. TIME OF INJURY
4:20 p.m. | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
Subject shot | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
wooded area | | | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)
5800 blk Columbia Park Dr. | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Mario F. Golle</i> | | | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/20/92 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mario F. Golle, MD 111 Penn Street Balto., MD. 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Randall</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be submitted to the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37457

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ANN Price | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 17 1992 | | 3. TIME OF DEATH
1:55 A | |
| 4. SOCIAL SECURITY NUMBER
230-10-6885 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
78 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
SEPT 11, 1914 | | 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
P.G. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Cheverly | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
3514 55th Avenue | | 10f. ZIP CODE
20784 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) --- | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Statistic Analyst | | 16b. KIND OF BUSINESS/INDUSTRY
Department of Agriculture | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles B. Price | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nellie Regnier | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Judith R. Mangubat | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3514 55th Avenue, Cheverly, Maryland 20784 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 12/21/92 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Francis Gasch | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
b. arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Old Pulmonary embolism
diabetic mellitus | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
W. J. ... MD | | 29c. LICENSE NUMBER
D12879 | | 29d. DATE SIGNED (Month, Day, Year)
DEC 17, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALFONSO VALLE, M.D. 10701 TRAFLET DR, LARGO, MD 20772 | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | 32. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TEMP. 20

92 37458

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LOTTIE MURRILL | | | | 2. DATE OF DEATH
MONTH 12 DAY 16 YEAR 92 | | 3. TIME OF DEATH
1:30 P | |
| 4. SOCIAL SECURITY NUMBER
213-561221 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
95 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
8/9/1897 | |
| 8. BIRTHPLACE (State or Foreign Country)
DOVER, N.C. | | | | 9a. FACILITY NAME (If not institution, give street and number)
CARROLL MANOR NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
HYATTSVILLE MD | |
| 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | 10a. STATE
MD | | 10b. COUNTY
PRINCE GEORGES | |
| 10c. CITY, TOWN OR LOCATION
LANHAM | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
7912 GRANT DRIVE | |
| 10f. ZIP CODE
20706 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12th College (1-4 or 5+) FARM WORKER | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
FARM WORKER | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
ANTHONY MURRILL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
CALLIE MURRILL | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JAMES B. WHITE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7912 GRANT DRIVE LANHAM, MD. 20706 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK 12-12 LANBOVER, MD. | | | |
| 20c. LOCATION — City or Town, State | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
W.H. Bacon 276 | | | |
| 22. NAME AND ADDRESS OF FACILITY
W.H. BACON FUNERAL HOME INC.
3447 14th STREET, N.W. WASHINGTON, D.C. 20010 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| 24. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
12/16/92 | | | |
| 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
MARTHA ANNE SCHNEIDER MD | | | | 29c. LICENSE NUMBER
D26331 | | | |
| 29d. DATE SIGNED (Month, Day, Year)
12/16/92 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARTHA ANNE SCHNEIDER MD 5401 MACARTHUR BLVD NW WASH DC 20016 | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | | | 32. REGISTRAR'S SIGNATURE
Jana Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37459

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
DOROTHY MCCOY | | | | 2. DATE OF DEATH
MONTH 12 DAY 15 YEAR 92 | | 3. TIME OF DEATH
1:25 P.M. | |
| 4. SOCIAL SECURITY NUMBER
577-40-4037 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
60 YRS. | | 7. DATE OF BIRTH
MONTH April DAY 30 YEAR 1932 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Holy Cross Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Capital Heights | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
205 Pepper Court | | | | 10f. ZIP CODE
20743 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Counselor | | 16b. KIND OF BUSINESS/INDUSTRY
D.C. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Lendo McCoy | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sarah Ray | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Lendo W. McCoy (Nephew) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
205 Pepper Court Capital Heights, Md. 20743 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematorium or other place)
Fort Lincoln Cemetery 12/22/92 | | 20c. LOCATION — City or Town, State
Brentwood, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Janet C. Anderson</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Rollins Funeral Home, Inc.
4339 Hunt Place, N.E. Wash. D.C. 20019 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death
3 WEEKS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ADULT RESPIRATORY DISTRESS SYNDROME
OSTEOMYELITIS OF SACRUM
DIABETES MELLITUS | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Anthony Boakye M.D.</i> | | | | 29c. LICENSE NUMBER
D 36091 | | 29d. DATE SIGNED (Month, Day, Year)
12-15-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ANTHONY BOAKYE M.D. 8300 CORPORATE DR. LANDOVER MD 20785 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | 32. REGISTRAR'S SIGNATURE
<i>John Anderson-Randell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37460

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Phyllis Leola Morgal | | | | 2. DATE OF DEATH
MONTH 12 DAY 21 YEAR 92 | | 3. TIME OF DEATH
1:38 P M | |
| 4. SOCIAL SECURITY NUMBER
439-22-3642 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
66 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
10/30/1926 | |
| 8. BIRTHPLACE (State or Foreign Country)
New Orleans, La. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Washington Advent. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Takoma Park, Md. | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Md. | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Adelphi | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1904 Quebec St. | |
| 10f. ZIP CODE
20783 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Microbiologist | | | | 16b. KIND OF BUSINESS/INDUSTRY
Tulane Medical School | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Nicholas Charles Williams, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Vincenzina Chiarello | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Linda E. Gannon | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10603 Lakespring Way, Cockeysville, Md. 21030 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Md. Veterans Cemetery 12/24/92 Cheltenham, Md. | | | |
| 20c. LOCATION — City or Town, State | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
H. Constance Jasch | | | |
| 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home, 4739 Baltimore Ave., Hyattsville, Md. 20781 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
John Tauber MD | | | | 29c. LICENSE NUMBER
D08546 | | 29d. DATE SIGNED (Month, Day, Year)
12-21-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John Tauber 8216 Wisconsin Ave Bethesda Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 1992 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0422407 NONSPECIFIED
MORGAL, PHYLLIS ER
12-21-92 F 066T 10-30-26
N/R # 295591

92 37461

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOSE | | | | 2. DATE OF DEATH
MONTH 12 DAY 19 YEAR 92 | | | | 3. TIME OF DEATH
12:38 A.M. | |
| 4. SOCIAL SECURITY NUMBER
594- 60- 7416 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
33 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
OCTOBER 23, 1959 | | 8. BIRTHPLACE (State or Foreign Country)
EL SALVADOR | |
| 9a. FACILITY NAME (If not institution, give street and number)
HOLY CROSS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRING | | | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
MONTGOMERY COUNTY | | 10c. CITY, TOWN OR LOCATION
TAKOMA PARK | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7667 MAPLE AVE APT# 311 | | | | 10f. ZIP CODE
20912 | | 10g. CITIZEN OF WHAT COUNTRY?
EL SALVADOR | | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: HISPANIC | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 5th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
CLEANER | | | | 16b. KIND OF BUSINESS/INDUSTRY
HIGH SCHOOL | |
| 17. FATHER'S NAME (First, Middle, Last)
JOSE S. MEJIA | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARIA F. GUZMAN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
SANTOS B. MEJIA | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BROTHER 7667 MAPLE AVE APT# 311 TAKOMA PARK, MD. 20912 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
FAMILY CEMETERY | | 20c. LOCATION — City or Town, State
12-28 EL SALVADOR | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
W. F. Bacon 276 | | | | 22. NAME AND ADDRESS OF FACILITY
W.H. BACON FUNERAL HOME INC.
3447 14th STREET, N.W. WASHINGTON, D.C. 20010 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
12-19-1992 | | 28b. TIME OF INJURY
12:08A.M. | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED
PEDESTRIAN STRUCK BY VAN | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
ON STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
CAMERON & GEORGIA AVE | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Mario F. Golie, Jr. MD | | | | 29c. LICENSE NUMBER
O.C.M.E. | | | | 29d. DATE SIGNED (Month, Day, Year)
12-19-1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLIE, JR. MD 11 PENN STREET BALTIMORE MARYLAND 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | | | 32. REGISTRAR'S SIGNATURE
Johia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21205-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37462

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EVELYN L. MURPHY | | | | 2. DATE OF DEATH
MONTH 12 DAY 20 YEAR 92 | | 3. TIME OF DEATH
0302 AM | |
| 4. SOCIAL SECURITY NUMBER
217-34-2403 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
6-28-33 | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash., DC | | | | 9a. FACILITY NAME (If not institution, give street and number)
SOUTHERN MD HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | |
| 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | 10a. STATE
Md. | | 10b. COUNTY
Calvert | |
| 10c. CITY, TOWN OR LOCATION
Lusby | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
P.O. Box 210 | |
| 10f. ZIP CODE
20657 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Banker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Banking | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Everett Harkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Marie Hoffman | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Martin M. Murphy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10a.-10f. | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Mary's Cemetery 12-22-92 | | | |
| 20c. LOCATION — City or Town, State
Washington, D.C. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Joseph B. St...</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Road
Clinton, Md. 20735 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumococcal pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

Approximate Interval Between Onset and Death
3 wks | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year)

 | | | | 28b. TIME OF INJURY
M | | | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED

 | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

 | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

 | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William J. Oetgen, MD</i> | | | | 29c. LICENSE NUMBER
D-16129 | | 29d. DATE SIGNED (Month, Day, Year)
12/20/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. William J. Oetgen, M.D., 9131 Piscataway Rd., #600, Clinton, Md. 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37463

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Charles, Murray | | | | 2. DATE OF DEATH
MONTH 12 DAY 16 YEAR 92 | | | | 3. TIME OF DEATH
3:02 P M | |
| 4. SOCIAL SECURITY NUMBER
218-24-6664 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
80 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JULY 25, 1912 | | 8. BIRTHPLACE (State or Foreign Country)
OKLAHOMA | |
| 9a. FACILITY NAME (If not institution, give street and number)
Montgomery General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Olney | | | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
SILVER SPRING | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
15115 INTERLACHEN DRIVE, #909 | | | | 10f. ZIP CODE
20906 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5 +)
3 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
DIRECTOR OF FINANCE | | | | 16b. KIND OF BUSINESS/INDUSTRY
OAS | |
| 17. FATHER'S NAME (First, Middle, Last)
FLORENCE LEROY MURRAY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
FLOSSIE BROWN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ESTHER W. MURRAY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15115 INTERLACHEN DRIVE, #909, SILVER SPRING, MD 20906 | | | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY 12/18 | | | | 20c. LOCATION — City or Town, State
ALEXANDRIA, VA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
David H. Kahl | | | | 22. NAME AND ADDRESS OF FACILITY
FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W., SIL. SP., MD 2090 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Thrombosis @ Superficial Femoral Vein with
DUE TO (OR AS A CONSEQUENCE OF):
b. Massive Emboli Bilateral Lung
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypotension
DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | Approximate Interval Between Onset and Death
Day
1 hr Day |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
1. Duodenal Ulcer - Stress Ulcer
2. Parkinsonism 3. Hip Fracture @ Total Hip replacement 12/92
4. Coronary Artery Disease | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
DR. WARREN, FERRIS | | | | 29c. LICENSE NUMBER
D31508 | | 29d. DATE SIGNED (Month, Day, Year)
12/17/92 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
3305 North Leisure World Blvd, Silver Spring MD 20906 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-17-50

92 37464

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Alexandra Milles | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 19, 1992 | | 3. TIME OF DEATH
12:15 p M | |
| 4. SOCIAL SECURITY NUMBER
075-26-5544 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
98 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
March 30, 1894 | |
| 8. BIRTHPLACE (State or Foreign Country)
Russia | | | | 9a. FACILITY NAME (If not institution, give street and number)
7527 Spring Lake Drive C-2 | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | |
| 9c. COUNTY OF DEATH
Montgomery | | | | 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | |
| 10c. CITY, TOWN OR LOCATION
Bethesda | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
7527 Spring Lake Drive # C-2 | |
| 10f. ZIP CODE
20817 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Dimitri/Not Available | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Helen/Not Available | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Natalie Pawlow | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7527 Spring Lake Drive Bethesda, Maryland 20817 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) December 21, 1992
Russian Orthodox Convent Cemetery | | | |
| 20c. LOCATION — City or Town, State
Spring Valley, New York | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Robert A. Pumphrey M00335 | | | |
| 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557
Avenue Bethesda, Maryland 20814 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year)
12 19 92
28b. TIME OF INJURY
A M
28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURED
IN BED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
HOME
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
#10 | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Francis C. Mayle M.D. | | | |
| 29c. LICENSE NUMBER
07099 | | | | 29d. DATE SIGNED (Month, Day, Year)
December 20, 1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Francis C. Mayle M.D. 10215 Fernwood Road Bethesda, Maryland 20817 | | | | 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | | |
| 32. REGISTRAR'S SIGNATURE
John Davidson | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, our item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37465

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Philip S. McNeill</u> | | | | 2. DATE OF DEATH
MONTH <u>12</u> DAY <u>12</u> YEAR <u>1992</u> | | 3. TIME OF DEATH
<u>4:15</u> M | |
| 4. SOCIAL SECURITY NUMBER
<u>577-48-3282</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>99</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<u>Feb. 23, 1893</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Mississippi</u> | | | | 9. COUNTY OF DEATH
<u>Montgomery</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>Kensington Garden Nursing Center</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Kensington</u> | | | |
| 10a. STATE
<u>Md.</u> | | | | 10b. COUNTY
<u>Prince George</u> | | 10c. CITY, TOWN OR LOCATION
<u>Upper Marlboro</u> | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<u>10125 Prince Place</u> | | | |
| 10f. ZIP CODE
<u>20772</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
<u>WWI</u> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>Black</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u>
College (1-4 or 5+) <u>College</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>Mover</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Private Industry</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Lafayette McNeill</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Melvina Lewis</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Florence McNeill</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>10125 Prince Place, Upper Marlboro, Md. 20772</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Quantico National Cem.</u> | | 20c. LOCATION — City or Town, State
<u>Triangle, Virginia</u> | | 20d. DATE
<u>Dec. 12, 1992</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Randolph Horton</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>R. N. Horton Co. Morticians, Inc.</u>
<u>600 Kennedy Street, N. W.</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory Arrest</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): <u>Cardiorespiratory Failure</u> | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): <u>Aspiration Pneumonitis</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): <u>Congestive Heart Failure</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Marked from Deficiency Aneurism</u>
<u>Colon Carcinoma, Primary</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>SK Gupta MD</u> | | | | 29c. LICENSE NUMBER
<u>D-32332</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>Dec. 12, 1992</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>9801 Georgia Avenue #220 Silver Spring, Md. 20902</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>DEC 21 '92</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11/11/82

11/11/82

92 37466

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Rose C. Muccio | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 23, 1992 | | 3. TIME OF DEATH
12:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER
149-22-3600 | | 5. SEX
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec. 10, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Shady Grove Adventist Nursing Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rockville | | 9c. COUNTY OF DEATH
Montgomery | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Rockville | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
128 New Mark Esplanade | | | | 10f. ZIP CODE
20850 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 16. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Beautician | | 16b. KIND OF BUSINESS/INDUSTRY
Beauty Salon | | | |
| 17. FATHER'S NAME (First, Middle, Last)
James Spero | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Philomena Lupone | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Erna A. Ruitenbergh | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
128 New Mark Esplanade, Rockville, Maryland 20850 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Holy Sepulchre Cemetery | | 20c. LOCATION — City or Town, State
Totowa Boro, New Jersey | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael E. Harris</i> M00846 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue
Bethesda, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral hemorrhage</i>
DUE TO (OR AS A CONSEQUENCE OF): <i>CVA</i>
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>HTN</i>
<i>Aphasia, Aphasia</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I
<i>History of ulcers and pneumonia</i> | | | | | | Approximate Interval Between Onset and Death | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S. Sudhakar MD</i> | | | | 29c. LICENSE NUMBER
D35792 | | 29d. DATE SIGNED (Month, Day, Year)
12-23-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S. SUDHAKAR 50 W. EDMONSTON DR, R, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rodell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE SE

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37467

| | | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Robert B. Marsden | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 22 92 | | 3. TIME OF DEATH
4:04 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER
215-14-8718 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Aug. 27, 1920 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Shady Grove Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Rockville | | | 9c. COUNTY OF DEATH
Montgomery | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Potomac | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER
10701 MacArthur Blvd. | | | | 10f. ZIP CODE
20854 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 8+)
2 | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Clerk | | | 16b. KIND OF BUSINESS/INDUSTRY
F.B.I. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank Marsden | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nettie Hill | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Dola B. Marsden | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10701 MacArthur Blvd., Potomac, Maryland 20854 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Potomac United Methodist Church Cem. 12/29/92 | | | 20c. LOCATION — City or Town, State
Potomac, Maryland | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Robert A. Pumphrey</i> M00198 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>MULTIPLE MYELOMA</i>
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF): <i>Renal Failure</i>
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. <i>Hypertension</i> | | | | | | | | Approximate Interval Between Onset and Death
26 mo. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Renal Failure</i>
<i>Hypertension</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Robert B. Marsden</i> | | | | 29c. LICENSE NUMBER
D2962J | | 29d. DATE SIGNED (Month, Day, Year)
Dec. 23, 1992 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert B. Marsden 14808 Physicians Ln Rockville, MD 20850 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>Sonia Davidson</i> | | | | | | | |

Page 25



92 37468

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Theodore C. MECHER</i> | | | | 2. DATE OF DEATH
MONTH <i>11</i> DAY <i>26</i> YEAR <i>92</i> | | 3. TIME OF DEATH
<i>2310 P M</i> | | |
| 4. SOCIAL SECURITY NUMBER
<i>577-32-7559</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>63</i> YRS. | | 7. DATE OF BIRTH
Month, Day, Year
<i>FEB. 4, 1929</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>SUBURBAN HOSPITAL 8600 OLD GEORGETOWN RD.</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>BETHESDA</i> | | 9c. COUNTY OF DEATH
<i>MONTGOMERY</i> | | |
| 10a. STATE
<i>MARYLAND</i> | | 10b. COUNTY
<i>MONTGOMERY</i> | | 10c. CITY, TOWN OR LOCATION
<i>KENSINGTON</i> | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
<i>10118 ashwood drive</i> | | | | 10f. ZIP CODE
<i>20895</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>WHITE</i> | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12TH GRADE</i>
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>SALESMAN</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>OFFICE SUPPLY</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>N/A</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>N/A</i> | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>CAROLYN A. MEKER</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>10118 ASHWOOD DR. KENSINGTON, MD. 20895</i> | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>SUBURBAN CREMATORY</i> | | DATE
<i>12-2-92</i> | | 20c. LOCATION — City or Town, State
<i>SILVER SPRING, MD.</i> | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Joe Turner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>WATSON FUNERAL HOME 3435 14TH ST. NW WASH. DC 20010</i> | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARDIOVASCULAR collapse</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
<i>Cardiac ARRHYTHMIA</i>

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>CARCINOMA OF ESOPHAGUS - Squamous Cell</i>
<i>STATUS POST CHEMOTHERAPY + RADIATION THERAPY</i>
<i>7 months ago</i> | | | | | | | Approximate Interval Between Onset and Death
<i>1 hr</i>

<i>?</i> | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL:
1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one)
OTHER:
4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Eugene P. Libo M.D.</i> | | | | 29c. LICENSE NUMBER
<i>009470</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>1 Dec 92</i> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>10400 CONNECTICUT AVE KENSINGTON MD 20895</i> | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 07 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED BY DR TAUBER.

9

92 37469

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY Elizabeth | | | | 2. DATE OF DEATH
MONTH 12 DAY 2 YEAR 1992 | | 3. TIME OF DEATH
4:55 P M | |
| 4. SOCIAL SECURITY NUMBER
577-36-3579 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3/23/22 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Leland Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Riverdale | | 9c. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Md | | | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville | |
| 10d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 10e. STREET AND NUMBER
5805 42nd Avenue # 723 | | | |
| 10f. ZIP CODE
20781 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Cafeteria Worker | | 16b. KIND OF BUSINESS/INDUSTRY
P. G. County Schools | |
| 17. FATHER'S NAME (First, Middle, Last)
James McKinney | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maude (Unknown last name) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Richard A. McDonald | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8608 35th Ave., College Park, Md. | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 12/5/92 | | 20c. LOCATION — City or Town, State
Brentwood, Md. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jack D. Friend | |
| 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home, 4739 Baltimore Avenue Hyattsville, Md. 20781 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
PULMONARY HYPERTENSION
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY
M | | 26c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26d. DESCRIBE HOW INJURY OCCURED | | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Kol Bassel MD | | | | 29c. LICENSE NUMBER
D34231 | | 29d. DATE SIGNED (Month, Day, Year)
12/4/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print)
DEC 7 1992 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

83498 32



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Rachel Lynne Nicholson | | 2. DATE OF DEATH
MONTH DAY YEAR
12 12 1992 | | 3. TIME OF DEATH
6:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER
579-96-8556 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
16 YRS. | |
| 7. DATE OF BIRTH
(Month, Day, Year)
Sept. 20, 1976 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
170 West of Mile Marker 8 | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hancock | | 9c. COUNTY OF DEATH
Washington | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Oxon Hill | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
5116 Martin Drive | | 10f. ZIP CODE
20745 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Student | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas R. Nicholson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lynne Dee Smutney | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Thomas R. Nicholson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5116 Martin Dr. Oxon Hill, Md. 20745 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Resurrection Cemetery 12/17/92 | | 20c. LOCATION — City or Town, State
Clinton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Injuries

Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Highway | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
12/12/1992 | | 28b. TIME OF INJURY
6:30 P. M. | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
Occupant in Auto/Roadway/Truck Impact | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Highway | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
170 West of M.M.#8 | | 29a. CERTIFIER
(Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
 | |
| 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/13/1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dennis J. Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | 31. DATE FILED (Month, Day, Year)
DEC 14 1992 | | 32. REGISTRAR'S SIGNATURE
 | |

DMMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN THE LAW

ITEMS: 23 PART I, 27 PER MEO G-695 1/11/93 reb

92 37471

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
LLOYD THOMAS NEWMAN II | | | | 2. DATE OF DEATH
MONTH DAY YEAR
11 28 92 | | 3. TIME OF DEATH
4:10 P M | |
| 4. SOCIAL SECURITY NUMBER
219 35 8326 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
N/A YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
MAY 7, 1990 | |
| 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
LANHAM | |
| 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | 10a. STATE
MD | | 10b. COUNTY
PRINCE GEORGES | |
| 10c. CITY, TOWN OR LOCATION
SEABROOK | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
9867 GOOD LUCK RD #4 | |
| 10f. ZIP CODE
20706 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
N/A | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | |
| 17. FATHER'S NAME (First, Middle, Last)
LLOYD THOMAS NEWMAN JR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
INGMAR I. WILKINSON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
INGMAR I. WILKINSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9867 GOOD LUCK RD. #4 SEABROOK, MD | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HARMONY MEMORIAL 12/2/92 | | 20c. LOCATION — City or Town, State
LANDOVER, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
RALPH WILLIAMS FUNERAL SVC
719 KENNEDY ST. N.W. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER
Check only 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
11/29/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
TARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 14 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Registrar certifies that the death certificate is executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37472

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ROSE G. NICOLosi | | | | 2. DATE OF DEATH
MONTH 12 DAY 20 YEAR 92 | | 3. TIME OF DEATH
6:04 P M | |
| 4. SOCIAL SECURITY NUMBER
577-16-6583 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
April 14, 1916 | |
| 8a. FACILITY NAME (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
CLINTON | | 8c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Temple Hills | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4105 28th Ave. | | | | 10f. ZIP CODE
20748 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
at home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Nicolo Genua | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Angelina Mazza | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Carmella N. Harris | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2318 Jameson St. Temple Hills, Md. 20748 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 12/23/92 | | 20c. LOCATION — City or Town, State
Suitland, Md. | | 20d. DATE
12/23/92 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
Respiratory Failure
CHRONIC OBSTRUCTIVE LUNG DISEASE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death
2 wks | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Heart Failure severe acute.
RENAL FAILURE ACUTE | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D24945 | | 29d. DATE SIGNED (Month, Day, Year)
December 20, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Michael Levine, M.D. 801 OLD BRANCH AVE #409 CLINTON MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37473

1 - FOR
STATE
REGISTRAR

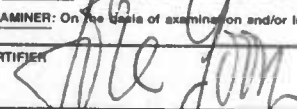

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELVIDA B. NIDDS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC. 20, 1992 | | 3. TIME OF DEATH
6:05 A M | |
| 4. SOCIAL SECURITY NUMBER
090-05-8813 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
87 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
JUNE 17, 1905 | | 8. BIRTHPLACE (State or Foreign Country)
NEW YORK | |
| 9a. FACILITY NAME (If not institution, give street and number)
HOLY CROSS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
SILVER SPRING | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD. | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
ROCKVILLE | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
14226 ARCTIC AVE. | | | | 10f. ZIP CODE
20853 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CHIEF TELEPHONE OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY
G.S.A., FED. GOV'T. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM LAWTON KING | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MINNIE B. ROE | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ETHEL M. NIDDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAME AS ITEM #10 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
FLUSHING CEMETERY 12/24/92 | | 20c. LOCATION — City or Town, State
FLUSHING, N.Y. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 W00091 | |
| 22. NAME AND ADDRESS OF FACILITY
W. W. CHAMBERS CO., RIVERDALE, MD. 20737 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

ARTIAL FIBRILLATION
DIABETES MELLITUS | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ARTIAL FIBRILLATION
DIABETES MELLITUS | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
816495 | | 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOEL GOOZH 4701 RANDOLPH RD ROCKVILLE MD 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | 32. REGISTRAR'S SIGNATURE
 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37474

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Amelia Farmer Nicholson | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 19, 1992 | | 3. TIME OF DEATH
5:05 A M | |
| 4. SOCIAL SECURITY NUMBER
217-46-7989 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
78 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 4, 1914 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Frederick Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Frederick | | 9c. COUNTY OF DEATH
Frederick | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Rockville | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
406 Great Falls Road | | | | 10f. ZIP CODE
20850 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (14 or 5+) - | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Robert Watt Farmer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Priscilla Dawson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William T. Nicholson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
406 Great Falls Road, Rockville, Maryland 20850 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Rockville Cemetery 12/22/92 | | 20c. LOCATION — City or Town, State
Rockville, Maryland | | 20d. DATE
12/22/92 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michelle P. Ketta</i> M00348 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave.
Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i>
DUE TO (OR AS A CONSEQUENCE OF):

b. <i>Infected Decubitus ulcer</i>
DUE TO (OR AS A CONSEQUENCE OF):

c.
DUE TO (OR AS A CONSEQUENCE OF):

d.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Infected gastrostomy</i>
<i>Renal failure</i>
<i>Alzheimers</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>James A. Frizzell</i> | | | | 29c. LICENSE NUMBER
D16637 | | 29d. DATE SIGNED (Month, Day, Year)
12/19/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James A. Frizzell, 915 Toll House Ave #201, Frederick Md 21701 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 21 '92 | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Wp 10 28



92 37475

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Cathie Nassif</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>12-7-92</i> | | 3. TIME OF DEATH
<i>6:30p</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>021-12-9721</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>75</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>11-2-17</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>5813 Marlboro Pike, #102</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>District Heights</i> | | 9c. COUNTY OF DEATH
<i>Prince George's</i> | |
| 10a. STATE
<i>Md.</i> | | 10b. COUNTY
<i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION
<i>District Heights</i> | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>5813 Marlboro Pike, #102</i> | | | | 10f. ZIP CODE
<i>20747</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
<i>WWII</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
<i>White</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Carpenter</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Carpentry</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Baracat Nassif</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Rosa Rastom</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Alice M. Nassif</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2910 Lantern Dr., South Daytona, FL 32119</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Arlington Nat'l Cemetery</i> | | 20c. LOCATION — City or Town, State
<i>Arlington, Va.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Lee Funeral Home, Inc.
6633 Old Alexander Ferry Road
Clinton, Md. 20735</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic obstructive pulmonary disease</i>
DUE TO (OR AS A CONSEQUENCE OF):

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Asbestos related sis</i> | | | | | | | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Augusto P. Rodriguez, M.D.</i> | | | | 29c. LICENSE NUMBER
<i>D21230</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12-7-92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 10 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

VITAL RECORDS, P.O. BOX 13146,

DIVISION 8

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEPT 22

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
NUTWELL LEROY WILLIAM JOSEPH NUTWELL | | | | 2. DATE OF DEATH
MONTH 12 DAY 3 YEAR 92 | | 3. TIME OF DEATH
9:18 A M | |
| 4. SOCIAL SECURITY NUMBER
577-05-1738 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
08/01/1913 | |
| 8a. FACILITY NAME (If not institution, give street and number)
Leland Memorial Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH
Riverdale | | 8c. BIRTHPLACE (State or Foreign Country)
Washington, D.C. | |
| 9a. STATE
Md. | | | | 9b. COUNTY
Prince George's | | 9c. INSIDE CITY LIMITS?
1 YES 2 NO | |
| 10a. STREET AND NUMBER
5104 Berwyn Road | | | | 10b. ZIP CODE
20740 | | 10c. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
10 Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY
Food Industry Nabisco | |
| 17. FATHER'S NAME (First, Middle, Last)
Albert L. Nutwell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Alice R. Simpson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Nell Irene Nutwell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5104 Berwyn Rd., College Park, Md. 20740 | | | |
| 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery | | 20c. DATE
12/5/92 | | 20d. LOCATION — City or Town, State
Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSÉE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home., 4739 Baltimore Avenue Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Bronchogenic CARCINOMA
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
1 year |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA
OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. MANNER OF DEATH
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
N/A | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 YES 2 NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
DD1852 | | 29d. DATE SIGNED (Month, Day, Year)
12-3-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Paul A. DeVore MD 4203 Greensbury Rd Hyattsville MD 20781 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 07 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Lydia R. Nieves | | | | 2. DATE OF DEATH
MONTH DAY YEAR
November 28, 1992 | | | | 3. TIME OF DEATH
1:40 P. M. | |
| 4. SOCIAL SECURITY NUMBER
582-34-9754 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
56 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Nov. 8, 1936 | | 8. BIRTHPLACE (State or Foreign Country)
Puerto Rico | |
| 9a. FACILITY NAME (If not institution, give street and number)
9516 Beech Park Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Capitol Heights | | | | 9c. COUNTY OF DEATH
Prince Georges | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Forestville | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8103 Phelps Place | | | | 10f. ZIP CODE
20747 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Puerto Rican | | 14. RACE — American Indian, Black, White, etc.
Specify: white | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do not use retired.)
Home maker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Agustin Rivera | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Josefina Rodriguez | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Carmen H. Gerakos | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11028 Braddock Dr. Culver City, CA 90230 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington National Cemetery 12/2/92 Suitland, MD | | 20c. LOCATION — City or Town, State | | 20d. DATE
12/2/92 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Buya & Grebach</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Marshall's Funeral Home, Inc. Suitland, MD 20746
4308 Suitland Rd. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>INANITION</i>
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. <i>Adenocarcinoma cell lung cancer, stage III</i>
c. <i>14 2 mos.</i> | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Daughter's home</i> | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
<i>Capital Heights, Maryland</i> | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Carl J. [Signature]</i> | | 29c. LICENSE NUMBER
<i>14730</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12-11-92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Carl J. [Signature], 8926 Woodyard Road #201, Clarks, MD 20738</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 11 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE SE

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
EDNA EARLE OATES | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 6 1992 | | 3. TIME OF DEATH
11:03 A M | |
| 4. SOCIAL SECURITY NUMBER
261-30-5517 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
NOV 13 1906 | |
| 8. BIRTHPLACE (State or Foreign Country)
CONNECTICUT | | | | 9a. FACILITY NAME (If not institution, give street and number)
NATIONAL NAVAL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | |
| 9c. COUNTY OF DEATH
MONTGOMERY | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
PRINCE GEORGE'S | |
| 10c. CITY, TOWN OR LOCATION
HYATTSVILLE | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
1384 CHILLUM ROAD | |
| 10f. ZIP CODE
20718 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) Unavailable
College (1-4 or 5+) Unavailable | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Payroll Clerk | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
RALPH ROBINSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
BRITINA STYRON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
EDWARD SWANN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1122 LAKE BLANCHE DRIVE, ORLANDO, FL 32808 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arlington Nat'l Cemetery 12/10/92 | | 20c. LOCATION — City or Town, State
Arlington, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack D Friend</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>W.C. Finneran</i> | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
12/7/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. C. FINNERAN, III, LT, MC, USNR | | | | 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | |
| 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

1000 - 30

92 37479

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARCELLA L. OLDFATHER | | | | 2. DATE OF DEATH
MONTH 12 DAY 23 YEAR 1992 | | 3. TIME OF DEATH
1:15 A.M. | |
| 4. SOCIAL SECURITY NUMBER
230-20-8892 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Jan. 31, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country)
Missouri | | | | 9a. FACILITY NAME (If not institution, give street and number)
Greenbelt Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Greenbelt | |
| 9c. COUNTY OF DEATH
Prince George's Co. | | | | 10a. STATE
Md. | | 10b. COUNTY
P.G. | |
| 10c. CITY, TOWN OR LOCATION
Hyattsville | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
4900 Gallatin St. | |
| 10f. ZIP CODE
20781 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) ———— | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Administrator | | 16b. KIND OF BUSINESS/INDUSTRY
Clerical | |
| 17. FATHER'S NAME (First, Middle, Last)
Franklin — Card | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elva — Morris | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary M. Keenan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5916 Mentana St. New Carrollton, Md. 20748 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ———— | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 12/26 | | 20c. LOCATION — City or Town, State
Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Thomas S. Chamber</i> #1670 | | | | 22. NAME AND ADDRESS OF FACILITY
W.W. Chambers Co. Inc.
5801 Cleveland Ave. Riverdale, Md. 20737 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Non-small cell carcinoma of lung
DUE TO (OR AS A CONSEQUENCE OF):
b. Cigarette abuse
DUE TO (OR AS A CONSEQUENCE OF):
c. ————
DUE TO (OR AS A CONSEQUENCE OF):
d. ————

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease
Radiation pneumonia
Bronchiectasis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) ———— | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
12/23/92 | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Norton Elson MD</i> | | | | 29c. LICENSE NUMBER
D20362 | | 29d. DATE SIGNED (Month, Day, Year)
12/23/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Norton Elson 6525 Belknap Rd Hyattsville MD 20782 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 24 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37480

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Louis OWEN | | | | 2. DATE OF DEATH
MONTH 12 DAY 30 YEAR 1992 | | | | 3. TIME OF DEATH
3:05P M | | | |
| 4. SOCIAL SECURITY NUMBER
127-09-5854 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 19, 1918 | | 8. BIRTHPLACE (State or Foreign Country)
New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Drs. Hospital (Community) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | | | | 9c. COUNTY OF DEATH
P.G. County | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
3810 Oliver St. | | | | 10f. ZIP CODE
20782 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Builder | | | | 16b. KIND OF BUSINESS/INDUSTRY
Home Improvement | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Robert Owen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lottie Kuhn | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Marie Owen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3810 OLiver St, Hyattsville, MD 20782 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lutheran Cemetery 1/4/93 | | 20c. LOCATION — City or Town, State
Middle Village, N.Y. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Charles C. Blasiak | | | | 22. NAME AND ADDRESS OF FACILITY
Baker Funeral Home
9320 West St., Manassas, VA 22110 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardiac arrest

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
Ischemic cardiomyopathy
Dissecting aortic aneurysm

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
D. melanoma
Renal failure | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
John C. Hattenberg | | | | 29c. LICENSE NUMBER
016197 | | | |
| 29d. DATE SIGNED (Month, Day, Year)
12-31-92 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type-Print)
A.C. LARA 9232 Lakewood-Southern RD. Lakewood, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 05 1993 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmission form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
McKinley Lee Price III | | | 2. DATE OF DEATH
MONTH 12 DAY 13 YEAR 1992 | | 3. TIME OF DEATH
7:00 A.M. | | |
| 4. SOCIAL SECURITY NUMBER
215 13 6682 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
19 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
08/19/73 | | |
| 8. BIRTHPLACE (State or Foreign Country)
Wash., D.C. | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
Indian Head Highway | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Fort Washington | | 9c. COUNTY OF DEATH
Prince Georges | | |
| 10a. STATE
Maryland | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Ft. Washington | | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
9814 Jacqueline Drive | | | 10f. ZIP CODE
20744 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Volunteer Firefighter | | 15b. KIND OF BUSINESS/INDUSTRY
Public safety | | | |
| 17. FATHER'S NAME (First, Middle, Last)
MCKINLEY PRICE, JR. | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
HELEN JONES | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
HELEN PRICE (MOTHER) | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9814 Jacqueline Drive, Ft Wash., Md. 20744 | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
HARMONY MEM PARK 12/19 | | 20c. LOCATION — City or Town, State
Landover, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Alex S. Pope</i> M859 | | 22. NAME AND ADDRESS OF FACILITY
ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike District Hts, MD 20747 | | | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>unknown injuries</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Highway | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
12/13/1992 | | 28b. TIME OF INJURY
4:51A. | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED
Driver in Auto/Tree Impact | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Indian Head Highway near Fort Washington Road | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Maqie Ouellet</i> | | | | | |
| | | 29c. LICENSE NUMBER
O C M E | | 29d. DATE SIGNED (Month, Day, Year)
12/13/1992 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HARMONY P. KORSUN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 16 1992 | | 32. REGISTRAR'S SIGNATURE
<i>John D. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92 37482

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Arturo PEREZ</u> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<u>December 15 1992</u> | | 3. TIME OF DEATH
HOUR MIN AM/PM
<u>9:10 A M</u> | |
| 4. SOCIAL SECURITY NUMBER
<u>578-72-7686</u> | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<u>38</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>March 12, 1954</u> | |
| 8. BIRTHPLACE (State or Foreign Country)
<u>Havana, Cuba</u> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<u>Doctors Community Hospital</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>Lanham</u> | |
| 9c. COUNTY OF DEATH
<u>Prince George</u> | | | | 10a. STATE
<u>Maryland</u> | | 10b. COUNTY
<u>Prince George's</u> | |
| 10c. CITY, TOWN OR LOCATION
<u>Lanham</u> | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<u>9115 Wellington Place</u> | |
| 10f. ZIP CODE
<u>20706</u> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <u>Cuban</u> | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <u>3</u> College (1-4 or 5+) <u>3</u> | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<u>Computer Field Engineer</u> | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Recognition Equipment</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Jesus Perez</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Eleuteria Perez</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Joyce E. Perez</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>9115 Wellington Place, Lanham, Maryland 20706</u> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>Resurrection Cemetery 12-18-92</u> | | 20c. LOCATION — City or Town, State
<u>Clinton, Maryland</u> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>Jeff Macrin</u> | |
| 22. NAME AND ADDRESS OF FACILITY
<u>Rendon/Hale Lanham Funeral Home</u>
<u>9013 Annapolis Rd., Lanham, Maryland 20706</u> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. CARDIO PULMONARY ARREST</u>
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. <u>SUBDURAL AND SUBARACHNOID HEMORRAGE</u> HOURS
DUE TO (OR AS A CONSEQUENCE OF):

c. <u>CEREBRAL CONTUSION</u> HOURS
DUE TO (OR AS A CONSEQUENCE OF):

d. <u>CHRONIC FALLING 2° AUTONOMIC NEUROPATHY</u> MONTHS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>SEVERE DIABETES MELLITUS</u>
<u>CHRONIC RENAL FAILURE</u>
<u>SEIZURE DISORDER</u> | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>[Signature]</u> | | | | 29c. LICENSE NUMBER
<u>D31069</u> | | 29d. DATE SIGNED (Month, Day, Year)
<u>12-16-92</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>George Bone, M.D. 9602-F Martin Luther King Hwy, Lanham, Maryland 20706</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>DEC 17 1992</u> | | 32. REGISTRAR'S SIGNATURE
<u>Joshua Davidson-Randall</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21. 3. 56

21. 3. 56

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DERRICK J. PENNY | | | | 2. DATE OF DEATH
MONTH 12 DAY 20 YEAR 1992 | | 3. TIME OF DEATH
12:56 A M | |
| 4. SOCIAL SECURITY NUMBER
215 19 9557 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
20 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
08 07 72 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number)
PKWY NORTH BOUND BALTO&WASHINGTON | | 9b. CITY, TOWN OR LOCATION OF DEATH
Cheverly | |
| 9c. COUNTY OF DEATH
PRINCE GEORGE | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Ft Washington | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
912 Palmer Road #1 | |
| 10f. ZIP CODE
20744 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11th | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | 16b. KIND OF BUSINESS/INDUSTRY
Private | |
| 17. FATHER'S NAME (First, Middle, Last)
Thomas M. Penny, Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Gail L. Beatty | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Thomas M. Penny Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5300 Brinkley Rd/Temple Hill, Md 20748 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Harmony Memorial Park 12/23/92 | | 20c. LOCATION — City or Town, State
Landover, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>James G. Neal Sr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY
J. B. Jenkins Funeral Home
7474 Landover Rd/Landover, Md 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
12-20-1992 | | 28b. TIME OF INJURY
12:55a | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED
DRIVER IN AUTO/TREE IMPACT | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
PARKWAY | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
P.G. MD
NORTH BOUND BALTO/WASHINGTON | | | |
| 29a. CERTIFIER
(Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Marko F. Golub, Jr.</i> | | | | 29c. LICENSE NUMBER
O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year)
12-20-1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARKO F. GOLUB, JR. 111 N. PENN ST BALTIMORE, MARYLAND 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
PAUL | | | | 2. DATE OF DEATH
MONTH 12 DAY 16 YEAR 1992 | | | | 3. TIME OF DEATH
7:03 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER
233-16-3858 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 8, 1916 | | 8. BIRTHPLACE (State or Foreign Country)
Madison Co., N.C. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
3901 OLIVER STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
HYATTSVILLE | | | | 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Prince George's | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
3901 Oliver St. | | | | 10f. ZIP CODE
20782 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) ----- | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Painter | | 16b. KIND OF BUSINESS/INDUSTRY
Decorating | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Jonas Payne | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elva Rankin | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Merrilyn Payne | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19 Laddar Hill Dr. South, Wheaton, Conn. 06883 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Metropolitan Funeral Ser. 12/19/92 Alexandria, Va. | | 20c. LOCATION — City or Town, State | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Constance Gasch</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home
4739 Baltimore Ave., Hyattsville, Md. 20781 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gunshot Wound of Head (intentional)
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
HEAD ONLY | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
12/16/1992 | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
(GUNSHOT)
SELF INFLICTED WOUND | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>A. M. Dixon</i> | | 29c. LICENSE NUMBER
O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year)
12/17/1992 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
A. M. Dixon
111 Penn Street, Baltimore, Maryland 21201 | | 31. DATE FILED (Month, Day, Year)
DEC 21 1992 | | 32. REGISTRAR'S SIGNATURE
<i>Joshua Davidson-Randall</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained at the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 must be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RALPH WILLIAM POLK | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 22 92 | | 3. TIME OF DEATH
2:45 AM | |
| 4. SOCIAL SECURITY NUMBER
578-05-8683 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12/28/15 | |
| 8. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGE'S HOSPITAL CENTER | | | | 9. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | | 10. COUNTY OF DEATH
PRINCE GEORGE'S | |
| 11. RESIDENCE OF DECEDENT
11a. STATE: Va.
11b. COUNTY: Shenandoah
11c. CITY, TOWN OR LOCATION: Mt. Jackson
11d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 12. STREET AND NUMBER
Rt # 1 Box 222 | | | | 13. ZIP CODE
22842 | | 14. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 16. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 18. RACE — American Indian, Black, White, etc.
Specify: White | |
| 19. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th
College (1-4 or 5+) ----- | | 20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Painter | | 21. KIND OF BUSINESS/INDUSTRY
Self Employed | | | |
| 22. FATHER'S NAME (First, Middle, Last)
Franklin H. Polk | | | | 23. MOTHER'S NAME (First, Middle, Maiden Surname)
Maude Estep | | | |
| 24. INFORMANT'S NAME (Type/Print)
Patricia A. Brey | | 25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15707 Letcher Rd. East Brandywine, Md. 20613 | | | | | |
| 26. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 12/24/92 Brentwood, Md. 20722 | | 28. LOCATION — City or Town, State
Brentwood, Md. 20722 | | | |
| 29. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 30. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home, 4739 Baltimore Ave., Hyattsville, Md. 20781 | | | |
| 31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Failure
Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. End Stage Hepatic Failure
c. Alcoholic Cirrhosis
d. | | | | | | | Approximate interval between Onset and Death |
| 32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 33. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 34. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 35. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 36. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 37. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 38. 28a. DATE OF INJURY (Month, Day, Year) | | 39. 28b. TIME OF INJURY
M | | 40. 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 41. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 42. 28f. DESCRIBE NOW INJURY OCCURRED | | | |
| | | 43. 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 44. 29a. CERTIFIER
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 45. 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> MD | | | | 46. 29c. LICENSE NUMBER
MD D16273 | | 47. 29d. DATE SIGNED (Month, Day, Year)
12/22/92 | |
| 48. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
REVAUGH MURPHY 6130 LANDOVER RD, LANDOVER MD | | | | | | | |
| 49. 31. DATE FILED (Month, Day, Year)
DEC 24 1992 | | 50. 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

92 37486

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LINA PINNEY | | | | 2. DATE OF DEATH
MONTH DEC. DAY 21 YEAR 1992 | | 3. TIME OF DEATH
1:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER
577-26-0843 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
OCT. 11, 1898 | |
| 8. FACILITY NAME (If not Institution, give street and number)
GREATER LAUREL BELTSVILLE HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LAUREL | | 9c. COUNTY OF DEATH
PRINCE GEORGES | |
| 10a. STATE
MD. | | | | 10b. COUNTY
MONTGOMERY | | 10c. CITY, TOWN OR LOCATION
SILVER SPRING | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
2101 FAIRLAND RD. | | | |
| 10f. ZIP CODE
20904 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 6 College (1-4 or 5+) HOUSEWIFE | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY
AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last)
UNKNOWN PAOLI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print)
JOSEPH J. DePRATO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
945 DECESARIS DR., LOTHIAN, MD. 20711 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
FT. LINCOLN CEMETERY 12/24/92 | | 20c. LOCATION — City or Town, State
BRENTWOOD, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>W.W. Chambers</i> MOOO91 | | | | 22. NAME AND ADDRESS OF FACILITY
W. W. CHAMBERS CO., RIVERDALE, MD. 20737 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):
Senility

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>John M. Davis</i> MD | | 29c. LICENSE NUMBER
D24283 | |
| 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 37) (Type, Print)
M. YUSUF MD. 3450 Fort Meade Road Laurel MD 20707. | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>John M. Davis</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2-11-66

2-11-66

1

92 37487

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY K. PENNINGTON | | | | 2. DATE OF DEATH
MONTH 12 DAY 11 YEAR 1992 | | 3. TIME OF DEATH
4:25 P M | |
| 4. SOCIAL SECURITY NUMBER
172-22-4063 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
78 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
July 15, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number)
PRINCE GEORGES HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
CHEVERLY | |
| 9c. COUNTY OF DEATH
PG | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | |
| 10c. CITY, TOWN OR LOCATION
Temple Hills | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
2813 Colebrook Drive | |
| 10f. ZIP CODE
20748 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Food Service Manager | | 16b. KIND OF BUSINESS/INDUSTRY
U.S. Government | |
| 17. FATHER'S NAME (First, Middle, Last)
Eugene Kidwell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ruth Bigelow | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sidney L. Pennington | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
200 Captain Brendt Dr. Accokeek, MD 20607 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery 12/15/92 | | 20c. LOCATION — City or Town, State
Brentwood, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Diana J. Fubail</i> | | | | 22. NAME AND ADDRESS OF FACILITY
4308 Suitland Rd.
Marshall's Funeral Home, Inc. Suitland, MD 20746 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries with skull fracture + cerebral hemorrhage
• DUE TO (OR AS A CONSEQUENCE OF):
a. Hemorrhage
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year)
12-7-92 | | 28b. TIME OF INJURY
12:00 PM | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED
drive/bike - auto impact | | | |
| 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
Lawson St. @ 24th Avenue, Newlaw Heights, Prince Georges, MD | | | | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)
20748 | | | |
| 29c. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29d. SIGNATURE AND TITLE OF CERTIFIER
<i>August P. Reardon MD</i> | | | | 29e. LICENSE NUMBER
A 21230 | | 29f. DATE SIGNED (Month, Day, Year)
12-13-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert P. Reardon MD, 5009 Rayburn Ct. Cp Spn. Md 20748 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 15 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020


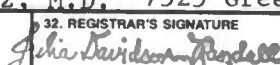
TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37488

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Anne B. Priarone | | | | 2. DATE OF DEATH
MONTH 12 DAY 19 YEAR 92 | | 3. TIME OF DEATH
5:30 A M | |
| 4. SOCIAL SECURITY NUMBER
579-40-9038 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
9-4-1916 | |
| 9a. FACILITY NAME (If not institution, give street and number)
3106 Gumwood Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Hyattsville | | 9c. COUNTY OF DEATH
Prince Georges | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Hyattsville | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3106 Gumwood Drive | | | |
| 10f. ZIP CODE
20783 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Executive Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
Federal Communications Commission. | |
| 17. FATHER'S NAME (First, Middle, Last)
Francesco A. Battinieri | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Maddalena Ricciardi | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Paolo Priarone | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3106 Gumwood Dr. Hyattsville, Maryland 20783 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | 20c. LOCATION — City or Town, State
12-22-92 Silver Spring, M.D. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home
11800 NewHampshire Ave. Silver Spring, M.D. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. respiratory failure
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. hepatic insufficiency
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. undifferentiated malignant neoplasm
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> OOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Martin David Weltz, M.D. | | | | 29c. LICENSE NUMBER
D23473 | | 29d. DATE SIGNED (Month, Day, Year)
12/21/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type, Print)
Martin David Weltz, M.D. 7525 Greenway Center Drive Suite#205 Greenbelt, M.D. 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 '92 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be secured within 24 hours after death. Page 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3)

92 37489

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARILYN ANN PANIKOWSKI | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26, 1992 | | 3. TIME OF DEATH
4:00 P. M | |
| 4. SOCIAL SECURITY NUMBER
059-36-1695 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
48 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
SEPT 18, 1944 | |
| 8. BIRTHPLACE (State or Foreign Country)
New York | | | | 9a. FACILITY NAME (If not institution, give street and number)
415 MEADOW CREEK LANE | | 9b. CITY, TOWN OR LOCATION OF DEATH
WALDORF | |
| 9c. COUNTY OF DEATH
Charles | | | | 10a. STATE
MARYLAND | | 10b. COUNTY
Charles | |
| 10c. CITY, TOWN OR LOCATION
WALDORF | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
415 MEADOW CREEK LANE | |
| 10f. ZIP CODE
20601 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Examiner | | 16b. KIND OF BUSINESS/INDUSTRY
Motor Vehicle Admin. | |
| 17. FATHER'S NAME (First, Middle, Last)
William Weaver | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Orletta Joseph | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Paul S. Panikowski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
415 Meadow Creek Lane, Waldorf, Md. 20601 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 12-30 Cheltenham, Md. | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE PERSON
<i>Bryan Matthews</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Huntt Funeral Home
P. O. Box 156, Waldorf, Md. 20604 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bacterial Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
b. Amyotrophic Lateral Sclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>S. Blaise Chromiak, MD</i> Attending Physician | | | | 29c. LICENSE NUMBER
D33431 | | 29d. DATE SIGNED (Month, Day, Year)
12/26/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S. Blaise CHROMIAK, MD 1902 R ST, NW Washington, DC 20009 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 29 '92 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37490

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
WALLACE CHARLES CYR | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Dec. 28, 1992 | | 3. TIME OF DEATH
11:15 A. M | |
| 4. SOCIAL SECURITY NUMBER
004-05-8491 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
12-29-1907 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Physicians Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LaPlata | | 9c. COUNTY OF DEATH
Charles | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Charles | | 10c. CITY, TOWN OR LOCATION
Waldorf | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
PO Box 394 Rt 301 | | | |
| 10f. ZIP CODE
20601 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) 12 years
College (1-4 or 5+) Accountant | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Accountant | | 16b. KIND OF BUSINESS/INDUSTRY
US Government | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles E. Cyr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Emma Theriault | | | |
| 19a. INFORMANT'S NAME (Type/Print)
James Joseph Cyr | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22 Ahern St West Hartford Connecticut 06110 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
St. Bruno | | 20c. LOCATION — City or Town, State
Van Buren, ME | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
John A. Eberwein | | 22. NAME AND ADDRESS OF FACILITY
J.H. Eberwein Mortuary La Plata, MD | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fatal failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death: years
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Am Harris Charles G. Deputy ME | | | | 29c. LICENSE NUMBER
D-27348 | | 29d. DATE SIGNED (Month, Day, Year)
12/29/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Howard M. Haft, MD, 4F Industrial Park Drive, Waldorf, Maryland 20604 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 29 92 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37491

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY LOUISE ROHLS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 13, 1992 | | | | 3. TIME OF DEATH
2:45p.m. M | | | | | |
| 4. SOCIAL SECURITY NUMBER
217-36-7228 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH
(Month, Day, Year)
12 07 1939 | | 6. BIRTHPLACE (State or Foreign Country)
Washington, DC | |
| 9a. FACILITY NAME (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LANHAM SEABROOK | | | | 9c. COUNTY OF DEATH
PRINCE GEORGE'S CO. | | | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Prince George's | | | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3507 Madison Place | | | | | | 10f. ZIP CODE
20782 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Bindery Work | | | | 16b. KIND OF BUSINESS/INDUSTRY
Printing Company | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Melvin T. Parent | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Julia Condera | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert L. Rohls | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3507 Madison Place, Hyattsville, MD 20782 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 12/16/1992 | | | | 20c. LOCATION — City or Town, State
Brentwood, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jack D. Friend | | | | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of colon
b. Liver metastasis.
c. _____
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dr. Barry Hejlskov | | | | | | 29c. LICENSE NUMBER
D13339 | | 29d. DATE SIGNED (Month, Day, Year)
12/14/92 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Barry Hejlskov 201 20780 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 16 1992 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Registrar requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37492

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
LUCINDA RANDALL | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12 17 92 | | 3. TIME OF DEATH
1:10 am | |
| 4. SOCIAL SECURITY NUMBER
577-36-0499 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
111 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
5-10-1881 | |
| 8. FACILITY NAME (If not institution, give street and number)
Leland Memorial Hospital | | | | 9. CITY, TOWN OR LOCATION OF DEATH
Riverdale | | 10. COUNTY OF DEATH
Prince Georges | |
| 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Hyattsville | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
6200 20th Place | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
3 <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
8th | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Home Maker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Henry Powell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Hector Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Barbara Bennett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1913 Tree Top Lane—Silver Spring, Md. 20904 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Lawn Cemetery | | 20c. LOCATION — City or Town, State
Sharon Hill, Pa. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Walter S. Pope Jr. | | | | 22. NAME AND ADDRESS OF FACILITY
Alexander S. Pope Funeral Home
2617 Pa. Ave. S.E. Wash, DC. 20020 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis septic shock.
DUE TO (OR AS A CONSEQUENCE OF):
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
Infected decubitus ulcers.
DUE TO (OR AS A CONSEQUENCE OF):
Severe anemia
cardiac arrhythmia | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe anemia
cardiac arrhythmia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL:
1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER:
4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Greelapi MD | | | | 29c. LICENSE NUMBER
D24174 | | 29d. DATE SIGNED (Month, Day, Year)
12/17/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PADMAJA S. UDAPU 4409 East West Hwy Riverdale Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 22 1992 | | 32. REGISTRAR'S SIGNATURE
Johanna Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25 21+25

92 37493

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
DOROTHY SMITH RIECKS | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 4, 1992 | | 3. TIME OF DEATH
4:15 A M | |
| 4. SOCIAL SECURITY NUMBER
577-03-5425 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10/27/1907 | |
| 8. BIRTHPLACE (State or Foreign Country)
Washington, DC | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
PHYSICIANS MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
La Plata | | 9c. COUNTY OF DEATH
Charles | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Anne Arundel | | 10c. CITY, TOWN OR LOCATION
Deale | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
848 Mason Avenue | | | | 10f. ZIP CODE
20751 | | 10g. CITIZEN OF WHAT COUNTRY?
U. S. of A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 2 | | 15a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Stock Clerk | | 15b. KIND OF BUSINESS/INDUSTRY
Washington Wholesale Drug Exchange | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Adam F. Smith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Nannie V. Payne | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Louis C. Riecks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8903 Pensacola Place, Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 12-07-92 | | 20c. LOCATION — City or Town, State
Suitland, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Joseph B. Smith</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd., Clinton, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiomyopathy
congestive heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Dr. Pace</i> mp | | | | 29c. LICENSE NUMBER
D-22574 | | 29d. DATE SIGNED (Month, Day, Year)
12/4/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Timothy R. Pace, MD. P.O. Box 249 Waldorf, Maryland 20604 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

92 37494

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|--|-------------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HENRY Theodore Rinck, JR. | | | 2. DATE OF DEATH
MONTH DAY YEAR
12-8-92 | | 3. TIME OF DEATH
3:45 A M | | |
| 4. SOCIAL SECURITY NUMBER
578-01-2671 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4/14/1911 | |
| 8. FACILITY NAME (If not institution, give street and number)
Leland Memorial Hospital | | | 9a. CITY, TOWN OR LOCATION OF DEATH
Riverdale | | | 9b. COUNTY OF DEATH
Prince George's | |
| 10a. STATE
Maryland | | | 10b. COUNTY
Prince George's | | | 10c. CITY, TOWN OR LOCATION
Landover Hills | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 10e. STREET AND NUMBER
7123 Buchanan Street | | | 10f. ZIP CODE
20784 | |
| 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade
College (1-4 or 5+) ----- | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Policeman | | | 16b. KIND OF BUSINESS/INDUSTRY
District of Columbia | | | 17. FATHER'S NAME (First, Middle, Last)
Henry T. Rinck, Sr. | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bertha Cole | | | 19a. INFORMANT'S NAME (Type/Print)
Genevieve Rinck | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7123 Buchanan Street, Landover Hills, MD 20784 | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)
Cedar Hill Cemetery 12/11/92 | | | 20c. LOCATION — City or Town, State
Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Jack D. Friend | | | 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781 | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septicemia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. DUE TO (OR AS A CONSEQUENCE OF):
Ca. Larynx

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF): | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | 28a. DATE OF INJURY (Month, Day, Year)
12-8-92 | |
| 28b. TIME OF INJURY
M | | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
M.D. | | | 29c. LICENSE NUMBER
D 24283 | | | 29d. DATE SIGNED (Month, Day, Year)
12-8-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
M. YUSUF M.D. 3450 Fort Meade Road Laurel MD 20707 | | | 31. DATE FILED (Month, Day, Year)
DEC 10 1992 | | | 32. REGISTRAR'S SIGNATURE
Gail Davidson-Randall | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>MILDRED HANNAH REED</i> | | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>12-7-92</i> | | 3. TIME OF DEATH
<i>1710 P M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>577-03-7408</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>83</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>12/12/1908</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Pennsylvania</i> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Leland Memorial Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Riverdale</i> | | 9c. COUNTY OF DEATH
<i>P.G.</i> | |
| 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION
<i>Riverdale</i> | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>3917 Madison Street</i> | | | | 10f. ZIP CODE
<i>20781</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>10th Grade</i>
College (1-4 or 5+) <i>-----</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Own Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Charles Herget</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Mae Viola Smith</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Harold Reed</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3917 Madison Street, Hyattsville, MD 20781</i> | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Metropolitan Crematory</i> | | 20c. LOCATION — City or Town, State
<i>Alexandria, Virginia</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Jack D Friend</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave., Hyattsville, MD 20781</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>RESPIRATORY FAILURE</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>PNEUMONIA</i>
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>SEVERE ANEMIA</i>
<i>STROKE / CVA</i>
<i>BILATERAL PLEURAL EFFUSION</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David S. Estores MD</i> | | | | 29c. LICENSE NUMBER
<i>D43311</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>12/08/92</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>DAVID S. ESTORES, JR. MD 6001 LANDOVER RD CHEVERLY MD 20785</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>DEC 10 1992</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 52

92 37496

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<u>Paul E. Ragan</u> | | | | 2. DATE OF DEATH
MONTH <u>12</u> DAY <u>17</u> YEAR <u>92</u> | | | | 3. TIME OF DEATH
<u>6</u> P M | |
| 4. SOCIAL SECURITY NUMBER
<u>579-28-4985</u> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs, last birthday)
<u>81</u> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<u>2-24-11</u> | | 8. BIRTHPLACE (State or Foreign Country)
<u>WASH. DC</u> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<u>1306 GREYSWOOD RD.</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<u>ODDINTON</u> | | | | 9c. COUNTY OF DEATH
<u>Anne Arundel</u> | |
| 10a. STATE
<u>MARYLAND</u> | | | | 10b. COUNTY
<u>Anne Arundel</u> | | 10c. CITY, TOWN OR LOCATION
<u>ODDINTON</u> | | | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
<u>1306 GREYSWOOD RD.</u> | | 10f. ZIP CODE
<u>21113</u> | | 10g. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <u>WHITE</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>—</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<u>D.C. Fireman</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<u>Fire Department</u> | |
| 17. FATHER'S NAME (First, Middle, Last)
<u>Raymond H. Ragan</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<u>Myrtle May Howard</u> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<u>Michael Ragan</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>1085 Dogwood Circle, Mechanicsville, Md. 20659</u> | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<u>12-21-92</u>
<u>Ft. Lincoln Cemetery</u> | | | | 20c. LOCATION — City or Town, State
<u>Brentwood, Md.</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY
<u>Lee Funeral Home, Inc.</u>
<u>6633 Old Alexander Ferry Road</u>
<u>Clinton, Md. 20735</u> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CA Common Bile Duct</u>
DUE TO (OR AS A CONSEQUENCE OF):

Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Age, obesity, Diabetes</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<u>M</u> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<u>[Signature]</u> | | | | 29c. LICENSE NUMBER
<u>D24768</u> | |
| | | | | 29d. DATE SIGNED (Month, Day, Year)
<u>12/18/92</u> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<u>600 RIDGELY AVE. ANNAPOLIS, MD 21401</u> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<u>DEC 23 1992</u> | | | | 32. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
GEORGIE HORN RIDGELY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DEC 19, 1992 | | 3. TIME OF DEATH
4:55 P M | |
| 4. SOCIAL SECURITY NUMBER
578102972 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
OCT 16, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country)
Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number)
MALCOLM GROW USAF MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH
ANDREWS AFB, MD | |
| 9c. COUNTY OF DEATH
PRINCE GEORGES | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Forestville | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
5801 Marlboro Pike Apt 204 | |
| 10f. ZIP CODE
20747 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Cafeteria Employee | | 16b. KIND OF BUSINESS/INDUSTRY
P. G. County School Sys. | |
| 17. FATHER'S NAME (First, Middle, Last)
Casper Horn | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Beuna F. Knupp | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Wilfred N. Ridgely | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 a-f | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 12 22 92 | | 20c. LOCATION — City or Town, State
Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Lee Funeral Home, Inc.
6633 Old Alexander Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
DEC 19, 1992 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOHN V. GANDY, CAPT. USAF, MC | | | | 31. DATE FILED (Month, Day, Year)
DEC 23 1992 | | | |
| 32. REGISTRAR'S SIGNATURE
 | | | | 33. NAME AND ADDRESS OF FACILITY
MALCOLM GROW USAF MEDICAL CENTER
ANDREWS AFB, MD 20331-5300 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 50



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

92 37498

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
RAVEN BONITA RUDD | | | | 2. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 11, 1992 | | | | 3. TIME OF DEATH
8:20 A M | |
| 4. SOCIAL SECURITY NUMBER
579-17-3430 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
4 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
JUNE 4, 1988 | | 8. BIRTHPLACE (State or Foreign Country)
WASHINGTON, DC | |
| 9a. FACILITY NAME (If not institution, give street and number)
NIH | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BETHESDA | | | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| 10a. STATE
DC | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION
WASHINGTON, DC | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
5860 NEBRASKA AVENUE, NW | | | | 10f. ZIP CODE
20015 | |
| 10g. CITIZEN OF WHAT COUNTRY?
USA | | | | 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: BLACK | | | | 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) N/A | |
| 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
N/A | | | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | | 17. FATHER'S NAME (First, Middle, Last)
THOMAS B. RUDD, III | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bonita R. Tyson | | | | 19a. INFORMANT'S NAME (Type/Print)
BONITA TYSON RUDD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5860 NEBRASKA AVENUE, NW WASHINGTON, DC 20015 | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington National Cemetery 12-19 Suitland, Md. | | | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
J.P. Marshall | | | | 22. NAME AND ADDRESS OF FACILITY
Marshall's Funeral Home
4217 9th Street N.W. D.C. 20011 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. B. Inter Pulmonary Consolidation
DUE TO (OR AS A CONSEQUENCE OF):
b. AIDS
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
weeks
years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide
3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
W.D. Hoffman | | | | 29c. LICENSE NUMBER
D32696 | |
| 29d. DATE SIGNED (Month, Day, Year)
12/11/92 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William D. Hoffman, MD | | | | 31. DATE FILED (Month, Day, Year)
DEC 18 1992 | |
| 32. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Eleanor F. Rhinehart | | | | 2. DATE OF DEATH
MONTH DAY YEAR
December 20, 1992 | | 3. TIME OF DEATH
3:06 P M | |
| 4. SOCIAL SECURITY NUMBER
230-30-8261 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 25, 1930 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bethesda | | 9c. COUNTY OF DEATH
Montgomery | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Wheaton | |
| 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
12223 Bushey Drive | | | | 10f. ZIP CODE
20902 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Office Manager | | 16b. KIND OF BUSINESS/INDUSTRY
Manufacturing Company | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Hilton L. Grubbs | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Margaret P. Kibbler | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Betty A. Bittner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1917 Henry Road, Rockville, Maryland 20851 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Parklawn Memorial Park 12/23/92 | | 20c. LOCATION — City or Town, State
Rockville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Barbara J. McMullen Lawrence M00831 | | | | 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery
Avenue, Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. EXTENSIVE SMALL CELL LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death
3 MONTHS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Carolyn Hendricks MD. | | | | 29c. LICENSE NUMBER
D37234 | | 29d. DATE SIGNED (Month, Day, Year)
12/20/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CAROLYN HENDRICKS, MD 14808 PHYSICIANS LANE, ROCKVILLE MD 20850 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 23 '92 | | 32. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BOOK 52

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOHN R. STEELE Sr | | | | 2. DATE OF DEATH
MONTH DAY YEAR
12/17/92 | | 3. TIME OF DEATH
1:30 A | |
| 4. SOCIAL SECURITY NUMBER
578-40-9240 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
6/9/1932 | |
| 8. BIRTHPLACE (State or Foreign Country)
Takoma Pk, Md. | | | | 9a. FACILITY NAME (If not institution, give street and number)
Doctor's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lanham | |
| 9c. COUNTY OF DEATH
Prince George's | | | | 10a. STATE
Md. | | 10b. COUNTY
Prince George's | |
| 10c. CITY, TOWN OR LOCATION
Hyattsville | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
3700 Ingalls Avenue | |
| 10f. ZIP CODE
20784 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) ---- College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Marshall | | 16b. KIND OF BUSINESS/INDUSTRY
United States | |
| 17. FATHER'S NAME (First, Middle, Last)
John Roy Steele | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clara Marie Yates | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mrs. Sybil M. Steele | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3700 Ingalls Avenue, Hyattsville, Md. 20784 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Md. State Veterans Cemetery 12/21/92 | | 20c. LOCATION — City or Town, State
Cheltenham, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Gasch's Funeral Home
4739 Baltimore Avenue., Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF): Constriction of lung
c. DUE TO (OR AS A CONSEQUENCE OF): chronic obstructive pulmonary disease
d. DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D09357 | | 29d. DATE SIGNED (Month, Day, Year)
12-17-92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
5804 Baltimore Ave Hyatts MD 20782 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
DEC 18 1992 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

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